Ontario

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Retain this instruction sheet for future reference and verification of applicable pages.
All changes appear in shaded text on the affected pages.

Remove Following Pages	Insert New Pages	Remove Following Pages	Insert New Pages
Table of Contents i – ii	Table of Contents i – ii	SP1 – SP2	SP1 – SP2
GP19 – GP20	GP19 – GP20	M1 – M18	M1 – M18
GP31 – GP32	GP31 – GP32	N1 – N52	N1 – N52
GP37 – GP38	GP37 – GP38	P1 – P10	P1 – P10
GP53 – GP54	GP53 – GP54	Q3 – Q4	Q3 – Q4
GP59 – GP62	GP59 – GP62	Q7 – Q10	Q7 – Q10
GP67 – GP68	GP67 – GP68	Q13 – Q14	Q13 – Q14
A1 – A4	A1 – A4	R1 – R2	R1 – R2
A7 – A12	A7 – A12	S1 – S6	S1 – S6
A27 – A28	A27 – A28	S17 – S20	S17 – S20
A31 – A32	A31 – A32	S25 – S28	S25 – S28
A35 – A38	A35 – A38	T9 – T12	T9 – T12
A51 – A58	A51 – A58	U1 – U8	U1 – U8
A61 – A66	A61 – A66	V1 – V10	V1 – V10
A75 – A76	A75 – A76	W1 – W2	W1 – W2
E5 – E6	E5 – E6	X5 – X8	X5 – X8
J23 – J24	J23 – J24	Y1 – Y16	Y1 – Y16
J29 – J30	J29 – J30	Z5 – Z12	Z5 – Z12
K7 – K8	K7 – K8	Z15 – Z16	Z15 – Z16
Numeric Index			
NI-1 – NI-4	NI-1 – NI-4	NI-43 – NI-44	NI-43 – NI-44
NI-9 – NI-10	NI-9 – NI-10	NI-59 – NI-60	NI-59 – NI-60
NI-15 – NI-16	NI-15 – NI-16	NI-99 – NI-100	NI-99 – NI-100
NI-37 – NI-38	NI-37 – NI-38	NI-113 – NI-120	NI-113 – NI-120

2007-03986/

TABLE OF CONTENTS
GENERAL PREAMBLE

Definitions 2

General Definitions 2
Maximums, Minimums, and Time or Unit-Based Services 6

General Information 7

Services Insured by *OHIP* 7
Modifications to the Schedule 7
Medical Research 7
Medical Records 8
General Payment Rules 9
Specialist Services 10
Use of Codes, Prefixes and Suffixes 10
Independent Consideration(IC) 12

Constituent and Common Elements of Insured Services 13

Specific Elements of Assessments 15

Consultations 16

Consultation 16
Repeat Consultation 16
Limited Consultation 17
Emergency Room (ER) Physician Consultation 17
Special Surgical Consultation 17

Assessments 18

General Assessment 18
Annual Health or Annual Physical Examination 18
General Re-Assessment 19
Pre-Operative and Pre-Dental General Assessment 19
Specific Assessment and Medical Specific Assessment 20
Specific Re-Assessment and Medical Specific Re-Assessment 20
Complex Medical Specific Re-Assessment 21
Partial Assessment 21
Chronic Disease Assessment Premium 21
Intermediate Assessment 23
Intermediate Assessment - Pronouncement of Death 23
Minor Assessment 24
Periodic Oculo-Visual Assessment 24
Detention 25
Detention - in - Ambulance 26
Detention for the Transport of Donor Organs 26
Newborn Care 27
Low Birth Weight Baby Care 27
Well Baby Care 27
Psychiatric Assessment under the *Mental Health Act* 27

TABLE OF CONTENTS
GENERAL PREAMBLE

Hospital and Institutional Consultations and Assessments **28**

Acute Care Hospital - Non-Emergency In-Patient Services ("C"-prefix services) 28
Admission Assessment - General Requirements 28
Admission Assessments by *Specialists* 28
Admission Assessments by General and Family Practitioners 29
Admission Assessments by Emergency Physicians 29
Subsequent Visit 30
Concurrent Care 33
Supportive Care 33
Long Term Care Institution: Non-Emergency In-Patient Services 34
Admission Assessment 34
Subsequent Visit 34
Emergency Department - "H" prefix Emergency Department Services 35
Palliative Care Assessment 35

Psychotherapy, Psychiatric, and Counselling Services **36**

Psychotherapy/Family Psychotherapy 37
Psychiatric Care/Family Psychiatric Care/
Primary Mental Health Care/ Paediatric Adolescent Care 38
Hypnotherapy 39
Counselling 39
Individual Counselling 39
Group Counselling 39
Transplant Counselling 40
Counselling of Relatives on Behalf of a Catastrophically
or Terminally Ill Patient 40
Rehabilitation Counselling 40

Interviews **41**

Delegated Procedure **42**

Special Visit Premiums **44**

Sacrifice of Office Hours Premium 44
Additional Patient Premium 45
Limits for Emergency Physicians 45
Restriction based on Volume of Special Visits 46
Special Visit Premiums - Fee Codes and Values 46
Special Visit for Obstetrical Delivery with Sacrifice of Office Hours 49

Team Care in Teaching Units **50**

Surgical Assistants' Services **51**

Calculation of Fee Payable: Basic Units and Time Units 51
After Hours Premium 52
Special Visit to Assist at Non-Elective Surgery 52
Cancelled Surgery - Assistant Services 53
Second Assistant 53
Surgical Assistant Standby 53

ASSESSMENTS

GENERAL RE-ASSESSMENT

Definition/Required elements of service:

A general re-assessment includes all the services listed for a general assessment, with the exception of the patient's history, which need not include all the details already obtained in the original assessment.

Payment rule:

With the exception of general re-assessments rendered for hospital admissions, general re-assessments are limited to two per *12 month period*, per patient per physician. The amount payable for general re-assessments in excess of this limit will be adjusted to a lesser assessment fee.

PRE-OPERATIVE AND PRE-DENTAL GENERAL ASSESSMENT

Definition/Required elements of service:

Pre-operative and Pre-dental general assessments are general assessments required prior to surgery or a dental procedure under anaesthesia in hospital.

Payment rule:

When a pre-operative assessment is followed within 30 days by an elective hospital admission, an admission general assessment (C003) or general re-assessment (C004) is *not eligible for payment*.

[Commentary:
Pre-operative and pre-dental general assessments constitute "general assessments" for the purpose of calculating general assessment limits set out above.]

SPECIFIC ASSESSMENT AND MEDICAL SPECIFIC ASSESSMENT

Definition/Required elements of service:

Specific assessment and medical specific assessment are services rendered by specialists, in a place other than a patient's home, and require a full history of the presenting complaint and detailed examination of the affected part(s), region(s), or system(s) needed to make a diagnosis, and/or exclude disease, and/or assess function.

Payment rule:

Specific assessments or medical specific assessments are limited to one per patient per physician *per 12 month period* unless either of the following circumstances are met in which case the limit is increased to two per patient per physician per *12 month period*:

1. the patient presents a second time with a complaint for which a clearly different diagnosis is made, unrelated to the diagnosis made at the time of the first specific assessment in that *12 month period*;

   or

2. in the case of a medical specific assessment, at least 90 days have elapsed since the date of the last specific assessment and the second assessment is a hospital admission assessment.

The amount payable for specific or medical specific assessments in excess of this limit will be adjusted to a lesser assessment fee.

In addition, any combination of medical specific assessments and complex medical specific re-assessments (see below) are limited to 4 per patient per physician per *12 month period*. The amount payable for these services in excess of this limit will be adjusted to a lesser assessment fee.

SPECIFIC RE-ASSESSMENT AND MEDICAL SPECIFIC RE-ASSESSMENT

Definition/Required elements of service:

Specific re-assessment and medical specific re-assessment are services rendered by specialists and require a full, relevant history and physical examination of one or more systems.

[Commentary:
As outlined on page GP28, admission assessments are deemed to be a specific re-assessment or medical specific re-assessment under either of the following circumstances:

1. for those procedures prefixed with a "Z" or noted as an IOP, by a surgical specialist who has assessed the patient prior to admission in respect of the same illness;

   or

2. for those patients who have been assessed by a physician and subsequently admitted to the hospital for the same illness by the same physician.]

Payment rule:

Specific re-assessments or medical specific re-assessments are limited to two per patient per physician per consecutive *12 month period* except for specific re-assessments rendered for hospital admissions. The amount payable for specific or medical specific re-assessments in excess of this limit will be adjusted to a lesser assessment fee.

C. Subsequent visit by the *Most Responsible Physician* (MRP)

Subsequent visit by the MRP – day following the hospital admission assessment (C122)

Definition:

Subsequent visit by the MRP - day following the hospital admission assessment is payable to the physician identified as the patient's MRP for rendering a subsequent visit on this day.

Subsequent visit by the MRP – second day following the hospital admission assessment (C123)

Definition:

Subsequent visit by the MRP - second day following the hospital admission assessment is payable to the physician identified as the patient's MRP for rendering a subsequent visit on this day.

Payment rules:

1. C122, C123 are limited to a maximum of one each per hospital admission.

   [Commentary:
   C122, C123 are only payable for visits rendered by the MRP. Services rendered by physicians who are not the MRP may be payable at a lesser visit fee.]

2. C122, C123 are *not eligible for payment*:

   a. when rendered to the same patient the same day as C124 (Subsequent visit by the MRP - day of discharge);

   b. for a patient admitted for obstetrical delivery or newborn care;

   or

   c. for any visit rendered by a surgeon during the 2 days prior to non-Z prefix surgery.

3. C122, C123 are not payable for a subsequent visit rendered by a surgeon to a hospital in-patient following non-Z prefix surgery.

   [Commentary:
   The first or second post-operative visits by the surgeon to a hospital in-patient following non-Z prefix surgery constitute post-operative visits payable at the appropriate specialty specific subsequent visit fee.]

4. When a patient is transferred to another physician within the same hospital during either of these days, C122 or C123 are only payable to the physician who was the MRP for the majority of the day.

5. When a patient is transferred to another physician at a different hospital, the day of transfer shall be deemed for payment purposes to be the day of admission.

Subsequent visit by the MRP - day of discharge (C124)

Definition/Required elements of service:

Subsequent visit by the MRP – day of discharge is payable to the physician identified as the MRP for rendering a subsequent visit on the day of discharge, and, in addition, requires completion of the discharge summary by the physician within 48 hours of discharge, arranging for follow-up of the patient (as appropriate) and prescription of discharge medications if any.

The discharge summary must include as a minimum the following information:

a. reason for admission;

b. procedures performed during the hospitalization;

c. discharge diagnosis;

and

d. medications on discharge.

Payment rules:

1. C124 is only payable to the MRP and limited to one service per hospital admission.
2. C124 is *not eligible for payment* under any of the following circumstances:
   - **a.** The patient was discharged within 48 hours of admission to hospital (calculated from the actual date of admission to hospital);
   - **b.** The admission was for obstetrical delivery unless the mother required admission to an ICU, with subsequent transfer and discharge from another unit within the hospital during the hospital stay;
   - **c.** The admission was for newborn care unless the infant was admitted to a NICU, with subsequent transfer and discharge from another unit within the hospital during the hospital stay;
   - **d.** For transfers within the same hospital;

     or

   - **e.** For discharges directly from a NICU or ICU where NICU or ICU critical care per diem services were rendered the same day.

[Commentary:
In the case of conflicting claims for this service, the physician to whom the patient has rostered (virtual or actual) may receive the payment for the service.]

GENERAL PREAMBLE

PSYCHOTHERAPY, PSYCHIATRIC AND COUNSELLING SERVICES

Payment rules:

1. These services are calculated and payable in time units of 30 minute increments. In calculating the time unit(s), the minimum time required in direct contact with the patient (or patient's relative or patient's representative as the case may be) and the physician in person is as follows:

# Units	Minimum time with patient
1 unit:	20 minutes
2 units:	46 minutes
3 units:	76 minutes [1h 16m]
4 units:	106 minutes [1h 46m]
5 units:	136 minutes [2h 16m]
6 units:	166 minutes [2h 46m]
7 units:	196 minutes [3h 16m]
8 units:	226 minutes [3h 46m]

2. Except for in-patient individual psychotherapy by a psychiatrist or in-patient individual psychiatric care for which the time can be consecutive or non-consecutive, for all other services in this section the time units must be calculated based upon consecutive time spent rendering the service.

3. Psychotherapy performed outside a hospital, psychiatric care, primary mental health care, or hypnotherapy rendered the same day as a consultation or other assessment by the same physician to the same patient is *not eligible for payment* unless there are clearly defined different diagnoses for the two services.

[Commentary:
Except as noted in payment rule #2 (where non-consecutive services can be cumulated), services less than 20 minutes do not constitute any of the services defined in this section and constitute the type of assessment rendered in the circumstances.]

PSYCHOTHERAPY/FAMILY PSYCHOTHERAPY

Definition:

Psychotherapy is as any form of treatment for mental illness, behavioural maladaptations, and/or other problems that are assumed to be of an emotional nature, where a physician deliberately establishes a professional relationship with a patient with the purpose of removing, modifying or retarding existing symptoms, or attenuating or reversing disturbed patterns of behaviour, and of promoting positive personality growth and development.

Family psychotherapy is psychotherapy rendered to the patient in the presence of one or more members of the patient's household.

Payment rules:

1. Psychotherapy is *not eligible for payment* when rendered on the same day to the same patient by the same physician as obstetrical delivery.

2. Subsequent visits rendered by the same psychiatrist to the same patient on the same day as in-patient individual psychotherapy are *not eligible for payment*.

PSYCHIATRIC CARE/FAMILY PSYCHIATRIC CARE/PRIMARY MENTAL HEALTH CARE/PAEDIATRIC ADOLESCENT CARE

Definition:

Psychiatric care/family psychiatric care/primary mental health care/paediatric adolescent care are services encompassing any combination or form of assessment and treatment by a physician for mental illness, behavioural maladaptations, and/or other problems that are assumed to be of an emotional nature, where there is consideration of the patient's biological and psychosocial functioning.

Family psychiatric care is psychiatric care of the patient carried out by the physician in the presence of one or more family members or in the presence of professional caregivers not on staff at the facility where the patient is receiving the care.

Payment rule:

Subsequent visits rendered by the same psychiatrist to the same patient on the same day as individual in-patient psychiatric care are *not eligible for payment*.

GENERAL PREAMBLE

SURGICAL ASSISTANTS' SERVICES

CANCELLED SURGERY – ASSISTANT SERVICES

Payment rules:

1. If the procedure is cancelled prior to induction of anaesthesia, the service constitutes a subsequent hospital visit.

2. When an anaesthetic has begun but the operation is cancelled due to a complication prior to commencement of surgery and the assistant has scrubbed but is not required to do anything further, the service is payable as E006B with the actual number of time units added to 5 basic units for this service.

   [Commentary:
   If the operation is cancelled after surgery has commenced, the amount payable is calculated by adding the listed procedural basic units plus time units and multiplying the total by the unit fee listed at the start of this section.]

SECOND ASSISTANT

Payment rule:

When more than one assistant was required for a surgical procedure, unless the service is listed below, the second assistant's service is *only eligible for payment* following authorization by a *medical consultant* and requires submission of a letter from the surgeon outlining the reason the second assistant was required. The amount payable for the second assistant is calculated in the same manner as the amount payable for the first assistant.

Services where a second assistant's services are payable and authorization is not required:

R240	R241	R326	R327	R440	R487
R594	S091	S092	S096	S098	S099
S213	S214	S267	S270	S271	S274
S275	S294	S295	S298	S300	S321
S416	S429	S440	S441	S453	

SURGICAL ASSISTANT STANDBY

Definition/Required elements of service:

E101B is a time-based service limited to one surgical case per physician per day payable for standby as a surgical assistant following a minimum of 30 minutes of unforeseen delay beyond the scheduled start time for surgery. The physician must be physically present in the operating room suite for the period between the scheduled and actual surgical start time.

Payment rules:

1. For calculation of time units, the start time for this service commences 30 minutes after the scheduled surgical start time and ends when the surgery actually commences as recorded in the hospital's operating suite records. There are no basic units.

2. E101B is *not eligible for payment* if during the standby time for which E101B would otherwise be eligible for payment, other insured services are rendered for which payment is made by *OHIP*.

   [Commentary:
   E101B is payable with after hour premiums.]

SPECIFIC ELEMENTS

In addition to the common elements, the general anaesthesia service includes the following specific elements.

A. Supervising the preparation of the patient for anaesthesia.

B. Performing the anaesthetic procedure, and procedures associated with the anaesthetic procedure which are not separately payable including providing all supportive measures to the patient during and immediately after the period of anaesthesia; transfer of or assisting with the transfer of the patient to the recovery room; all indicated recovery room procedures, and ongoing monitoring and detention during the immediate post-operative and recovery period.

C. Making arrangements for any assessments, procedures, or therapy, including obtaining any specimens (except for arterial puncture Z459), and/or interpreting the results, on matters related to the service.

D. Making, or supervising the making of, arrangements for follow-up care and when medically indicated, post-procedure monitoring of the patient's condition until the next insured service is provided.

E. Discussion with, and providing any advice and information, including prescribing therapy to the patient or the patient's representative(s), whether by telephone or otherwise, on matters related to the service.

F. Providing premises, equipment, supplies, and personnel for any aspect(s) of specific elements A, C, D, and E that is (are) performed in a place other than the place in which the general anaesthetic service is performed.

While no occasion may arise for performing elements C, D or E, when performed in connection with the other specific elements, they are included in the general anaesthetic service.

The general anaesthesia service includes:

a. a pre-anaesthetic evaluation, with specific elements as for assessments (see GP15);

b. the anaesthetic procedure;

and

c. post-anaesthetic follow-up.

Note:

1. With the exception of the listings in the "Consultations and Visits" section, all references to an anaesthesiologist in this *Schedule* are references to any physician providing anaesthetic services.
2. As per the definitions section (see GP2), general anaesthesia, for the purposes of this *Schedule*, includes all forms of anaesthesia except local infiltration.

CALCULATION OF FEE PAYABLE – BASIC AND TIME UNITS

The amount payable for the anaesthesia service is calculated by adding the number of basic and time units and multiplying the total by the anaesthesiologist unit fee.

Anaesthesiologist Unit fee **12.51**

GENERAL PREAMBLE

SUPPORTIVE CARE/MONITORING BY SURGICAL ASSISTANT OR ANAESTHESIOLOGIST

SPECIFIC ELEMENTS

In addition to the common elements, supportive care or monitoring by the surgical assistant or anaesthesiologist includes the following specific elements.

A. Being in constant attendance at a surgical procedure for the sole purpose of monitoring the condition of the patient (including appropriate physical examination and inquiry) and being immediately available to provide, and including the provision of, special supportive care to the patient.

B. Discussion with, and providing advice and information, including prescribing therapy to the patient or the patient's representative(s), whether by telephone or otherwise, on matters related to:

1. the service;

   and

2. in circumstances in which it would be professionally appropriate that results can be reported upon prior to any further patient visit, the results of related procedure(s) and/or assessment(s).

C. Providing premises, equipment, supplies, and personnel for any aspect(s) of the specific elements of the service that is(are) performed at a place other than the place in which the attendance occurs.

While no occasion may arise for performing element B, when performed in connection with the other elements it is included in the service.

CALCULATION OF FEE PAYABLE

The fee for this service is calculated in the same manner as for assistant and anaesthesia services.

		Asst	Anae
E003	Supportive care/Monitoring	5	5

Note:

1. For E003B, the assistants' premiums apply as for assistants' services.
2. For E003C, the anaesthesiologists' premiums apply as for anaesthesiologists' services.

INTENSIVE OR CORONARY CARE UNIT PREMIUM

C101 For each patient seen on a visit to ICU or CCU (subject to the exceptions set out below) . . . . . add 8.65

Payment rule:

C101 is *not eligible for payment* with Supportive Care or with Critical Care, Ventilatory Care, Comprehensive Care, or Neonatal Intensive Care where team fees are claimed.

[Commentary:
C101 is payable when no other separate fee is payable for the service provided in the ICU or CCU (e.g. post-operative care by surgeon).]

AFTER HOURS PROCEDURE PREMIUMS

These premiums are payable only when the following criteria are met:

a. the service provided is one of the following:

Non-elective Surgical Procedures (including fractures or dislocations), Obstetrical Deliveries, Clinical Procedures Associated with Diagnostic Radiological Examinations, Ground Ambulance Transfer (K101), Air Ambulance Transfer (K111), Transport of Donor Organs (K102), Return Trip (K112), or one of the following Major Invasive Procedures:

G082	G083	G085	G090	G091	G092	G099	G117	G118	G119	G125	G176
G177	G178	G179	G211	G246	G249	G261	G262	G263	G268	G269	G275
G277	G280	G282	G288	G294	G295	G297	G298	G303	G304	G309	G323
G324	G330	G331	G336	G347	G348	G349	G356	G380	G509	J001 to J068	

and:

b. the procedure is either (a) non-elective; or (b) an elective procedure which, because of an intervening surgical emergency procedure(s) was delayed and commenced between:

E409 Evenings (17:00h – 24:00h) Monday to Friday or daytime and evenings on Saturdays, Sundays, Holidays - increase the procedural fee(s) by 50%

E410 Nights (00:00h – 07:00h) - increase the procedural fee(s) by . . 75%

Payment rules:

1. E409/E410 is not payable in addition to the obstetrical fee(s) if labour is induced by medical and/or surgical means by the same physician, unless the reason for the induction is fetal distress, diabetes, premature rupture of membrane, severe pre-eclampsia, hypertension, abruption, or post-dates pregnancy. For the purpose of this provision, a forewater ARM or oxytocin augmentation of labour carried out on a patient in desultory labour does not constitute induction.

2. E409/E410 is not payable for a procedure rendered by a physician rendering services in an emergency department who at the time the service was rendered would have been required to submit claims using "H" prefix emergency services (see GP35 of the General Preamble).

AFTER HOURS SPECIAL VISIT PREMIUMS

Non-elective Diagnostic and Therapeutic Procedures

Subject to the provision set out immediately below, these special visit premiums are payable in addition to the fees listed for:

Non-elective Diagnostic and Therapeutic Procedures, including Laboratory Medicine, Nuclear Medicine, Radiation Oncology, Diagnostic Radiology, Clinical Procedures Associated with Diagnostic Radiology Examinations, Magnetic Resonance Imaging, Diagnostic Ultrasound, and Pulmonary Function Studies.

When a physician providing one or more of the foregoing services makes a special visit to the hospital during the time periods set out below for the purpose of interpreting the results of a diagnostic service, performing a procedure, seeing a patient in consultation or to conclude that a procedure is not medically indicated, a premium is payable in addition to the appropriate consultation, interpretation, or procedural fee, or by itself if the decision is made not to perform the procedure. For such services submit using:

C109	Evenings (17:00h – 24:00h) Monday to Friday or daytime and evenings on Saturdays, Sundays or Holidays.	36.30
C110	Nights (00:00h – 07:00h)	54.60

AFTER HOURS SPECIAL VISIT PREMIUMS

The following premiums are payable for maintenance/supervision for epidural catheter for relief of pain (G247) for visits rendered during the time periods set out below:

E402	Evenings (17:00h – 24:00h) Monday to Friday or daytime and evenings on Saturday, Sunday or Holidays	add 40%
E403	Nights (00:00h – 07:00h)	add 50%

Note:
See Nerve Blocks, Diagnostic and Therapeutic Procedures.

OTHER PREMIUMS

TRAUMA PREMIUM

Definition/Required elements of service:

The trauma premium is payable for each of the services and units described below when:

a. rendered either on the day of the trauma or within 24 hours of the trauma;

and

b. for trauma patients age 16 or more who have an Injury Severity Score (ISS) of greater than 15, or for patients less than age 16 who have an Injury Severity Score of greater than 12.

E420 Trauma premium ..... add 50%

Payment rules:

1. The premium is applicable to the following services and units:
   a. services listed in the Consultation and Visits Section (Section A of the *Schedule*);
   b. services listed in the Obstetrics Section (Section K of the *Schedule*);
   c. services listed in the Surgical Procedures section (Section M through Z of the *Schedule*);
   d. the following resuscitative services: G395, G391, G521, G522 and G523.
   e. basic and time units provided by surgical assistants;
   or
   f. basic and time units provided by anaesthesiologists.
2. The premium is payable only for the services for which the medical record lists the ISS score.

Claims submission instruction:

For claims payment purposes, the trauma premium and associated services must be submitted on the same claim record.

[Commentary:
Other special visit and after hours premiums are payable with services eligible for the trauma premium in accordance with the Schedule. However, the trauma premium is not applicable to these services.]

GENERAL PREAMBLE

HOSPITAL AND INSTITUTIONAL CONSULTATIONS AND ASSESSMENTS

Payment rules:

1. Except as outlined in payment rule #8, this service is *only eligible for payment* once per patient per calendar month.

2. This service is *only eligible for payment* to the MRP.

3. When W010 is rendered, none of the services listed as a component of W010 and rendered to the patient by any physician during the month are eligible for payment.

4. In the temporary absence of the patient's MRP (e.g. while that physician is on vacation), W010 remains payable to the patient's MRP if the service is performed by another physician.

5. In the event the MRP renders one "W" prefix assessment in a calendar month and the same physician has rendered W010 to that patient within the previous 11-month period, only that "W" prefix assessment in that month is eligible for payment.

6. In the event the MRP renders two, three or four "W" prefix assessments in a calendar month and the same physician has rendered W010 to that patient within the previous 11-month period, only W010 is eligible for payment.

7. In the event the MRP renders more than four "W" prefix assessments to the same patient in a month and the same physician has rendered W010 to that patient within the previous 11-month period, any subsequent visits for intercurrent illness rendered by the MRP to the same patient in excess of four in a month are payable as W121 in addition to payment of W010.

8. Despite the definition set out above, the requirements of W010 are met when less than two "W" prefix assessments were rendered during the month and/or when the patient was not in the institution for a full calendar month if:

   a. a patient was newly admitted to the institution and an admission assessment was rendered,

   or

   b. in the event of the death of a patient while in the institution or within 48 hours of transfer to hospital.

9. Age related premiums otherwise applicable to any component service of W010 are *not eligible for payment* in addition to W010.

Claims submission instructions:

1. Except in the circumstances described in payment rule #8, submit at the end of the month.

2. The admission date of the patient must be provided on the claim for W010 or the service is *not eligible for payment*.

3. Submit claims for W121 which meet the requirements outlined in payment rule #7 using the manual review indicator.

[Commentary:
Examples of services not included in the Monthly Management fee include:

   a. visits which qualify for a special visit premium.

   b. services described under interviews, psychotherapy or counselling with the patient, patient's relative(s) or patient's representative lasting 20 or more minutes and where all other criteria for these services are met.

   c. services rendered by a specialist who is not the MRP or who is not replacing an absent MRP.]

NOT ALLOCATED

CONSULTATIONS AND VISITS

GENERAL LISTINGS

A005	Consultation	56.10
A905	Limited consultation	44.65

Special palliative care consultation

A special palliative care consultation is a consultation requested because of the need for specialized management for palliative care where the physician spends a minimum of 50 minutes with the patient and/or patient's representative/family in consultation (majority of time must be spent in consultation with the patient). In addition to the general requirements for a consultation, the service includes a psychosocial assessment, comprehensive review of pharmacotherapy, appropriate counselling and consideration of appropriate community services, where indicated.

A945	Special palliative care consultation	127.50

Payment rules:

1. Start and stop times must be recorded in the patient's permanent medical record or the amount payable for the service will be adjusted to a lesser paying fee.
2. When the duration of a palliative care consultation (A945 or C945) exceeds 50 minutes, one or more units of K023 are payable in addition to A945 or C945, provided that the minimum time requirements for K023 are met. The time periods for A945 or C945 and K023 are mutually exclusive (i.e. the start time for determination of minimum time requirements for K023 occurs 50 minutes after start time for A945 or C945).

A006	Repeat consultation	42.35
A003	General assessment*	58.20

Note:
*Not to be billed for an assessment provided in the patient's home.

A004	General re-assessment	30.70

Note:
The papanicolaou smear is included in the consultation, repeat consultation, general or specific assessment (or re-assessment), annual health or routine post natal visit when pelvic examination is normal part of the foregoing services. However, the add-on code E430 can be billed in addition to these services when a papanicolaou smear is performed outside hospital.

Emergency Department equivalent - partial assessment

An Emergency Department equivalent - partial assessment is an assessment rendered in an Emergency Department Equivalent on a Saturday, Sunday or Holiday for the purpose of dealing with an emergency.

A888	Emergency Department equivalent - partial assessment	28.55

[Commentary:
Services described above must be submitted using only fee code A888.]

Payment rules:

1. Hypnotherapy or counselling rendered to the same patient by the same physician on the same day as A888 are not eligible for payment.
2. No premiums are payable for a service rendered in an Emergency Department equivalent.

House call assessment

A house call assessment is a primary care service rendered in a patient's home that satisfies, at a minimum, all of the requirements of an intermediate assessment.

A901 House call assessment 41.75

Payment rule:
A house call assessment is only eligible for payment for the first person seen during a single visit to the same location.

[Commentary:
Services rendered to additional patients seen during the same visit are payable at a lesser fee from the General Listings.]

House call assessment - Pronouncement of death in the home

A house call assessment - Pronouncement of death in the home is the service rendered when a physician pronounces a patient dead in a home. This service includes completion of the death certificate and counselling of any relatives which may be rendered during the same visit.

A902 House call assessment - Pronouncement of death in the home 41.75

Claims submission instruction:
Submit the claim using the diagnostic code for the underlying cause of death as recorded on the death certificate.

Note:
**For special visit premiums, please see pages GP43 to GP48 of the General Preamble.

A903 Pre-dental/pre-operative general assessment (maximum of 2 per 12-month period) 58.20

Note:
The amount payable for an admission general assessment (C003) or general re-assessment (C004) for an elective surgery patient for whom a pre-operative assessment has already been claimed, within 30 days of this pre-operative assessment is nil.

On-call admission assessment

On-call admission assessment is the first hospital in-patient admission general assessment per patient per 30-day period if:

a. the physician is a general practitioner or family physician participating in the hospital's on-call roster whether or not the physician is on-call the day the service is rendered;

b. the admission is non-elective;

and

c. the physician is the most responsible physician with respect to subsequent in-patient care.

The amount payable for any additional on-call admission assessment rendered by the same physician to the same patient in the same 30-day period is reduced to the amount payable for a general re-assessment.

A933 On-call admission assessment 79.20

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

General/Family Physician Emergency Department Assessment

General/Family Physician Emergency Department Assessment is an assessment of a patient that satisfies as a minimum the requirements of an intermediate assessment and is rendered by the patient's general/family physician in an emergency department funded under an Emergency Department Alternative Funding Agreement (ED AFA). For that visit, the service includes any re-assessment of the patient by the general/family physician in the emergency department and any appropriate collaboration with the emergency department physician.

The service is only eligible for payment when the general/family physician's attendance is required because of the complexity, obscurity or seriousness of the patient's condition.

A100	General/Family Physician Emergency Department Assessment	76.90

Payment rule:
No other service (including special visit or other premiums) rendered by the same physician to the same patient during the same visit to the emergency department is eligible for payment with this service.

Claims submission instruction:
For claims payment purposes, the hospital number associated with the emergency department must be submitted on the claim.

[Commentary:

1. Services described as A100 rendered in an emergency department not funded under an ED AFA may be payable under other existing fee schedule codes.
2. In the event the patient is subsequently admitted to hospital, and the general/family physician remains the MRP for the patient, the General/Family Physician Emergency Department Assessment constitutes the admission assessment. See General Preamble GP29 for additional information.]

Certification of death

Certification of death is payable to the physician who personally completes the death certificate on a patient who has been pronounced dead by another physician, medical resident or other authorized health professional. Claims submitted for this service must include the diagnostic code for the underlying cause of death as recorded on the death certificate. The service may include any counselling of relatives that is rendered at the same visit. Certification of Death rendered in conjunction with A902 or A777/C777 is an insured service payable at nil.

A771	Certification of death	17.75
A777	Intermediate assessment - Pronouncement of death (see General Preamble GP23)	30.20
A007	Intermediate assessment or well baby care	30.20
A001	Minor assessment	17.75

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Mini assessment

A mini assessment is rendered when an assessment of a patient for an unrelated non-WSIB problem is performed during the same visit as an assessment of a WSIB related problem for which only a minor assessment was rendered.

A008	Mini assessment	10.25

Annual health examination

K017	- child after second birthday*	30.40

Note:
*For Annual Adult/Adolescent health examinations - see General Preamble GP18.

Periodic Oculo-visual Assessment

See General Preamble GP24 for definitions and conditions.

A110	- aged 19 years and below	40.15
A112	- aged 65 years and above	40.15

Identification of patient for a Major Eye Examination

Identification of patient for a Major Eye Examination, is the service of determining that a patient aged 20 to 64 inclusive has a medical condition (other than diabetes mellitus, glaucoma, cataract, retinal disease, amblyopia, visual field defects, corneal disease or strabismus) requiring a major eye examination and providing such a patient with a completed requisition.

E077	- identification of patient for a Major Eye Examination	add	10.25

Note:

1. This service is limited to a maximum of one every four fiscal years by the same physician for the same patient unless the patient seeks a major eye examination from an optometrist or general practitioner other than the one to whom the original requisition was provided.
2. This service is limited to a maximum of one per fiscal year by any physician to the same patient.

CONSULTATIONS AND VISITS

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP33. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

C005	Consultation	56.10
C905	Limited consultation	49.60
C945	Special palliative care consultation - subject to the same conditions as A945	127.50
C006	Repeat consultation	42.35
C003	General assessment	58.20
C813	Midwife-Requested Assessment - subject to the same conditions as A813	81.60
C815	Midwife-Requested Special Assessment - subject to the same conditions as A815	127.50
C004	General re-assessment	30.70
C903	Pre-dental/pre-operative general assessment (maximum of 2 per 12-month period)	58.20
C933	On-call admission assessment - subject to the same conditions as A933	79.20
C777	Intermediate assessment - Pronouncement of death - subject to the same conditions as A777	30.20
C771	Certification of death - subject to the same conditions as A771	17.75

Subsequent visits

C002	- first five weeks	per visit	29.20
C007	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C009	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 for terms and conditions.

C122	- day following the hospital admission assessment	46.15
C123	- second day following the hospital assessment	46.15
C124	- day of discharge	46.15
C121	Additional visits due to intercurrent illness (see General Preamble GP31) per visit	29.20
C008	Concurrent care per visit	29.20
C010	Supportive care per visit	17.75
C882	Palliative care (see General Preamble GP35) per visit	29.20

Attendance at maternal delivery for care of high risk baby(ies)

Attendance at maternal delivery for high risk baby(ies) requires constant attendance at the delivery of a baby expected to be at risk by a physician who is not a paediatrician, and includes an assessment of the newborn.

H007	Attendance at maternal delivery for care of high risk baby(ies)	61.65

Payment rule:
This service is not eligible for payment if any other service is rendered by the same physician at the time of the delivery.

H001	Newborn care in hospital and/or home	52.20

Low birth weight baby care (uncomplicated)

H002	- initial visit (per baby)		32.75
H003	- subsequent visit	per visit	16.25

EMERGENCY DEPARTMENT - PHYSICIAN ON DUTY

Note:
See General Preamble GP35 for definitions and conditions for Physician on Duty.

In-patient interim admission orders

In-patient interim admission orders is payable to an emergency department (ED) physician who is on-call or on duty in the emergency department for writing in-patient interim admission orders pending admission of a "non-elective" patient by a different most responsible physician (see General Preamble GP3).

Comprehensive assessment and care

Comprehensive assessment and care is a service rendered in an emergency department that requires a full history (including systems review, past history, medication review and social/domestic evaluation), a full physical examination, concomitant treatment, and intermittent attendance on the patient over many hours as warranted by the patient's condition and ongoing evaluation of response to treatment.

It also includes the following as indicated:

a. interpretation of any laboratory and/or radiological investigation;

and

b. any necessary liaison with the following: the family physician, family, other institution (e.g. nursing home), and other agencies (e.g. Home Care, VON, CAS, police, or detoxification centre).

[Commentary:
Re-assessments, where required, are payable in addition to this service if the criteria described in the Schedule are met.]

Multiple systems assessment

A multiple systems assessment is an assessment rendered in an emergency department that includes a detailed history and examination of more than one system, part or region.

Re-assessment

A re-assessment is an assessment rendered in a Emergency Department at least two hours after the original assessment or re-assessment (including appropriate investigation and treatment), which indicates that further care and/or investigation is required and performed.

Payment rules:

1. This service is not eligible for payment under any of the following circumstances:
   a. for discharge assessments;
   b. when the patient is admitted by the physician on duty in the emergency department;

   or

   c. when the reassessment leads directly to a referral for consultation.
2. This service is limited to three per patient per day and two per physician per patient per day. Services in excess of these limits are not eligible for payment.

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

H065	Consultation in Emergency Medicine	57.40
H105	In-patient interim admission orders	18.45

Note:

1. H105 is payable in addition to the initial ED consultation or assessment provided that each service is rendered separately by the ED physician.
2. H105 is an insured service payable at nil if the hospital admission assessment is payable to the ED physician.

Monday to Friday - Daytime (08:00h to 17:00h)

H102	Comprehensive assessment and care	37.20
H103	Multiple systems assessment	32.25
H101	Minor assessment	15.00
H104	Re-assessment	15.00

Monday to Friday - Evenings (17:00h to 24:00h)

H132	Comprehensive assessment and care	40.90
H133	Multiple systems assessment	35.30
H131	Minor assessment	16.45
H134	Re-assessment	16.45

Saturdays, Sundays and Holidays - Daytime and Evenings (08:00h to 24:00h)

H152	Comprehensive assessment and care	55.80
H153	Multiple systems assessment	47.40
H151	Minor assessment	22.50
H154	Re-assessment	22.50

Nights (00:00h to 08:00h)

H122	Comprehensive assessment and care	65.10
H123	Multiple systems assessment	54.95
H121	Minor assessment	26.25
H124	Re-assessment	26.25

When any other service is rendered by the physician on duty in premium hours (and assessments may not be claimed), apply one of the following premiums per patient visit

H112	- nights (00:00h to 08:00h)	15.00
H113	- daytime and evenings (08:00h to 24:00h) on Saturdays, Sundays or Holidays	8.80

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patient(s) in the Emergency or OPD - use General Listings.

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

W105	Consultation	56.10
W106	Repeat consultation	42.35

Admission assessment

W102	- Type 1	58.20
W104	- Type 2	17.75
W107	- Type 3	30.70
W109	Annual physical examination	58.20
W777	Intermediate assessment - Pronouncement of death - subject to the same conditions as A777	30.20
W771	Certification of death - subject to same conditions as A771	17.75
W004	General re-assessment of patient in nursing home (per the *Nursing Homes Act*)	17.75

Note:
W004 may be claimed 6 months after Annual Health Examination (per the *Nursing Homes Act*).

W903	Pre-dental/pre-operative general assessment (maximum of 2 per 12-month period)	58.20
A777	Intermediate assessment - Pronouncement of death (see General Preamble GP23)	30.20

Subsequent visits (see General Preamble GP34)

Chronic care or convalescent hospital

W002	- first 4 subsequent visits per patient per month	per visit	29.20
W001	- additional subsequent visits (maximum 4 per patient per month)	per visit	13.40
W882	- palliative care (see General Preamble GP35)	per visit	29.20

Nursing home or home for the aged

W003	- first 2 subsequent visits per patient per month	per visit	22.55
W008	- additional subsequent visits (maximum 2 per patient per month)	per visit	13.40
W872	- palliative care (see General Preamble GP35)	per visit	29.20
W121	Additional visits due to intercurrent illness (see General Preamble GP34)	per visit	22.55

Monthly Management of a Nursing Home or Home for the Aged Patient

W010	Monthly management fee (per patient per month) (see General Preamble GP66 to GP67)		85.70

CONSULTATIONS AND VISITS

CARDIOLOGY (60)

For services not listed, refer to Internal Medicine Section

GENERAL LISTINGS

A605	Consultation	127.50
A675	Limited consultation	75.35
A606	Repeat consultation	75.35
A603	Medical specific assessment	58.25
A604	Medical specific re-assessment	45.90
A601	Complex medical specific re-assessment	53.15
A608	Partial assessment	29.05
E078	- chronic disease assessment premium (see General Preamble GP21)	add 30%

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP33. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

C605	Consultation	127.50
C675	Limited consultation	75.35
C606	Repeat consultation	75.35
C603	Medical specific assessment	58.25
C604	Medical specific re-assessment	45.90
C601	Complex medical specific re-assessment	53.15

Subsequent visits

C602	- first five weeks	per visit	29.20
C607	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C609	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 for terms and conditions.

C122	- day following the hospital admission assessment	46.15
C123	- second day following the hospital assessment	46.15
C124	- day of discharge	46.15
C121	Additional visits due to intercurrent illness (see General Preamble GP30) per visit	29.20
C608	Concurrent care per visit	29.20
C982	Palliative care (see General Preamble GP35) per visit	29.20

CONSULTATIONS AND VISITS

CARDIOVASCULAR & THORACIC SURGERY (09)

GENERAL LISTINGS

A095	Consultation	66.30
A935	Special surgical consultation (see General Preamble GP17)	127.50
A096	Repeat consultation	46.30
A093	Specific assessment	41.20
A094	Partial assessment	22.45

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP33. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

C095	Consultation	81.60
C935	Special surgical consultation (see General Preamble GP17)	127.50
C096	Repeat consultation	46.30
C093	Specific assessment	41.20
C094	Specific re-assessment	25.85

Subsequent visits

C092	- first five weeks	per visit	29.20
C097	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C099	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 for terms and conditions.

C122	- day following the hospital admission assessment	46.15
C123	- second day following the hospital assessment	46.15
C124	- day of discharge	46.15

C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C098	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP35)	per visit	29.20

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

W095	Consultation	66.30
W096	Repeat consultation	46.30

CONSULTATIONS AND VISITS

DERMATOLOGY (02)

GENERAL LISTINGS

A025	Consultation	59.15
A026	Repeat consultation	44.45
A023	Specific assessment	38.70
A024	Partial assessment	20.40

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patient(s) in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP33. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

C025	Consultation	59.15
C026	Repeat consultation	44.45
C023	Specific assessment	38.70
C024	Specific re-assessment	24.80

Subsequent visits

C022	- first five weeks	per visit	29.20
C027	- sixth to thirteenth week (maximum 3 per patient per week)	per visit	29.20
C029	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 for terms and conditions.

C122	- day following the hospital admission assessment		46.15
C123	- second day following the hospital assessment		46.15
C124	- day of discharge		46.15
C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C028	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP35)	per visit	29.20

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

W025	Consultation		59.15
W026	Repeat consultation		44.45

Subsequent visits (see General Preamble GP34)

Chronic care or convalescent hospital

W022	- first 4 subsequent visits per patient per month	per visit	29.20
W021	- additional subsequent visits (maximum 6 per patient per month)	per visit	13.80
W982	- palliative care (see General Preamble GP35)	per visit	29.20

Nursing home or home for the aged

W023	- first 2 subsequent visits per patient per month	per visit	22.55
W028	- additional subsequent visits (maximum 3 per patient per month)	per visit	13.80
W972	- palliative care (see General Preamble GP35)	per visit	29.20
W121	Additional visits due to intercurrent illness (see General Preamble GP34)	per visit	22.55

CONSULTATIONS AND VISITS

GENERAL SURGERY (03)

GENERAL LISTINGS

A035	Consultation	81.60
A935	Special surgical consultation (see General Preamble GP17)	127.50
A036	Repeat consultation	46.30
A033	Specific assessment	41.20
A034	Partial assessment	22.45

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP33. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

C035	Consultation	81.60
C935	Special surgical consultation (see General Preamble GP17)	127.50
C036	Repeat consultation	46.30
C033	Specific assessment	41.20
C034	Specific re-assessment	25.85

Subsequent visits

C032	- first five weeks	per visit	29.20
C037	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C039	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 for terms and conditions.

C122	- day following the hospital admission assessment	46.15
C123	- second day following the hospital assessment	46.15
C124	- day of discharge	46.15

C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C038	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP35)	per visit	29.20

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

W035	Consultation		81.60
W036	Repeat consultation		46.30

Subsequent visits (see General Preamble GP34)

Chronic care or convalescent hospital

W032	- first 4 subsequent visits per patient per month	per visit	29.20
W031	- additional subsequent visits (maximum of 6 per patient per month)	per visit	13.80
W982	- palliative care (see General Preamble GP35)	per visit	29.20

Nursing home or home for the aged

W033	- first 2 subsequent visits per patient per month	per visit	22.55
W038	- subsequent visits per month (maximum of 3 per patient per month)	per visit	13.80
W972	- palliative care (see General Preamble GP35)	per visit	29.20

W121	Additional visits due to intercurrent illness (see General Preamble GP34)	per visit	22.55

GENERAL LISTINGS

A645	Consultation	81.60
A935	Special surgical consultation (see General Preamble GP17)	127.50
A646	Repeat consultation	46.30
A643	Specific assessment	41.20
A644	Partial assessment	22.45

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP33. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

C645	Consultation	81.60
C935	Special surgical consultation (see General Preamble GP17)	127.50
C646	Repeat consultation	46.30
C643	Specific assessment	41.20
C644	Specific re-assessment	25.85

Subsequent visits

C642	- first five weeks	per visit	29.20
C647	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C649	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 for terms and conditions.

C122	- day following the hospital admission assessment		46.15
C123	- second day following the hospital assessment		46.15
C124	- day of discharge		46.15
C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C648	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP35)	per visit	29.20

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

W645	Consultation	81.60
W646	Repeat consultation	46.30

GENERAL LISTINGS

A225	Consultation*	142.80
A325	Limited consultation	75.35
A226	Repeat consultation	75.35
A221	Genetic minor assessment	29.05

Genetic assessment

A Genetic Assessment is a time based service that requires interviewing the appropriate family members, collection and assessment of adequate clinical and genetic data to make a diagnosis, construction/revision of a pedigree, and assessment of the risk to persons seeking advice. It also includes sharing this information and any options with the appropriate family members. Time units are calculated based on the duration of direct contact between the physician and the patient or family. Unit means ½ hour or major part thereof - see General Preamble GP6, GP37 for definitions and time-keeping requirements.

K016	Genetic assessment, patient or family	per unit	61.05

Payment rule:
This service is limited to 4 units per patient per day.

Genetic care

Genetic care is a time based service payable for rendering a genetic assessment. Time units are calculated based on the duration of direct contact between the physician and the patient or family. Unit means ½ hour or major part thereof - see General Preamble GP6, GP37 for definitions and time-keeping requirements.

K222	Genetic care, patient or family	per unit	61.05

Payment rule:
This service is limited to 4 units per patient, per day.

Clinical interpretation by a Geneticist

Clinical Interpretation by a Geneticist requires interpretation of pertinent pedigrees (which must contain a comprehensive ancestral history), and/or cytogenetic, biochemical, or molecular genetic reports. The service must be requested in writing by a physician who is participating in the patient's care and the geneticist must submit his/her findings, opinions, and recommendations in writing to the referring physician.

K223	Clinical interpretation	28.80

Payment rule:
This service is not eligible for payment when rendered in association with a consultation on the same patient.

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP33. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

C635	Consultation	65.70
C835	Special nuclear medicine - subject to the same conditions of A835	127.50
C735	Diagnostic consultation - subject to the same conditions as A735	29.20
C636	Repeat consultation	45.10

CONSULTATIONS AND VISITS

OBSTETRICS & GYNAECOLOGY (20)

GENERAL LISTINGS

A205	Consultation*	81.60
A935	Special surgical consultation (see General Preamble GP17)	127.50
A206	Repeat consultation*	45.85
A203	Specific assessment*	40.25
A204	Partial assessment	22.45

Note:
The Papanicolaou smear is included in the consultation, repeat consultation, general or specific assessment (or re-assessment), annual health or routine post-natal visit when pelvic examination is normal part of the foregoing services. However, the add-on code E430 can be billed in addition to these services when a papanicolaou smear is performed outside hospital.

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP33. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

C205	Consultation*	81.60
C935	Special surgical consultation (see General Preamble GP17)	127.50
C206	Repeat consultation*	45.85
C203	Specific assessment*	40.25
C204	Specific re-assessment*	25.15

Subsequent visits

C202	- first five weeks	per visit	29.20
C207	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C209	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 for terms and conditions.

C122	- day following the hospital admission assessment	46.15
C123	- second day following the hospital assessment	46.15
C124	- day of discharge	46.15

C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C208	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP35)	per visit	29.20

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

W305	Consultation*	81.60
W306	Repeat consultation*	45.85

Note:

*Includes (where indicated) biopsy of cervix, papanicolaou smear, examination of trichomonas suspension.

Note:
Ophthalmology consultations and visits may include retinal photography as a specific element of the insured service, where medically necessary.

GENERAL LISTINGS

A235	Consultation	66.30
A935	Special surgical consultation (see General Preamble GP17)	127.50
A236	Repeat consultation	45.85
A233	Specific assessment	42.15
A234	Partial assessment	22.45

Periodic Oculo-visual Assessment

A237	- aged 19 years and below	42.15
A239	- aged 65 years and above	42.15

Note:
See General Preamble GP24 for definitions and conditions.

Major Eye Examination

A115	Major eye examination (see page A5)	42.15

Orthoptic assessment

Orthoptic assessment must include quantitative measurement of all 11 positions of gaze (straight ahead, up, down, left, right, up-left, up-right, down-left, down-right, tilt-right and tilt-left), sensory testing for binocular vision, suppression, cyclodeviation, and retinal correspondence. Orthoptic assessments are payable in addition to an ophthalmology consultation or visit and only when medically necessary e.g. suspicion of strabismus, orbital fracture, thyroid disease etc. All findings must be documented in writing in the patient's permanent record. Orthoptic Assessment that does not include all measurements or in the absence of a written record is an insured service payable at nil.

A230	Orthoptic assessment	14.90

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP33. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

C235	Consultation	66.30
C935	Special surgical consultation (see General Preamble GP17)	127.50
C236	Repeat consultation	45.85
C233	Specific assessment	42.15
C234	Specific re-assessment	25.45

OPHTHALMOLOGY (23)

Subsequent visits

C232	- first five weeks	per visit	29.20
C237	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C239	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 for terms and conditions.

C122	- day following the hospital admission assessment	46.15
C123	- second day following the hospital assessment	46.15
C124	- day of discharge	46.15

C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C238	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP35)	per visit	29.20

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

W535	Consultation	66.30
W536	Repeat consultation	45.85

CONSULTATIONS AND VISITS

ORTHOPAEDIC SURGERY (06)

GENERAL LISTINGS

A065	Consultation	66.30
A935	Special surgical consultation (see General Preamble GP17)	127.50
A066	Repeat consultation	45.85
A063	Specific assessment	39.70
A064	Partial assessment	22.45

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP33. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

C065	Consultation		66.30
C935	Special surgical consultation (see General Preamble GP17)		127.50
C066	Repeat consultation		45.85
C063	Specific assessment		39.70
C064	Specific re-assessment		25.15

Subsequent visits

C062	- first five weeks	per visit	29.20
C067	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C069	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 for terms and conditions.

C122	- day following the hospital admission assessment		46.15
C123	- second day following the hospital assessment		46.15
C124	- day of discharge		46.15
C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C068	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP35)	per visit	29.20

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

W065	Consultation		66.30
W066	Repeat consultation		45.85

Subsequent visits (see General Preamble GP34)

Chronic care or convalescent hospital

W062	- first 4 subsequent visits per patient per month	per visit	29.20
W061	- additional subsequent visits (maximum of 6 per patient, per month)	per visit	13.80
W982	- palliative care (see General Preamble GP35)	per visit	29.20

Nursing home or home for the aged

W063	- first 2 subsequent visits per patient per month	per visit	22.55
W068	- subsequent visits per month (maximum of 3 per patient per month)	per visit	13.80
W972	- palliative care (see General Preamble GP35)	per visit	29.20

W121	Additional visits due to intercurrent illness (see General Preamble GP34)	per visit	22.55

GENERAL LISTINGS

A245	Consultation	66.30
A935	Special surgical consultation (see General Preamble GP17)	127.50
A246	Repeat consultation	45.85
A243	Specific assessment	39.70
A244	Partial assessment	22.45

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP33. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

C245	Consultation	66.30
C935	Special surgical consultation (see General Preamble GP17)	127.50
C246	Repeat consultation	45.85
C243	Specific assessment	39.70
C244	Specific re-assessment	25.15

Subsequent visits

C242	- first five weeks	per visit	29.20
C247	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C249	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 for terms and conditions.

C122	- day following the hospital admission assessment	46.15
C123	- second day following the hospital assessment	46.15
C124	- day of discharge	46.15

C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C248	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP35)	per visit	29.20

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

W345	Consultation	66.30
W346	Repeat consultation	45.85

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patient(s) in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP33. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

C265	Consultation	142.80
C667	Neurodevelopmental consultation - subject to same conditions as A667	255.00
C665	Prenatal consultation - subject to the same conditions as A665	68.15
C565	Limited consultation	75.35
C266	Repeat consultation	75.35
C263	Medical specific assessment	58.25
C264	Medical specific re-assessment	45.90
C661	Complex medical specific re-assessment	53.15

Subsequent visits

C262	- first six weeks	per visit	29.20
C267	- seventh to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C269	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 for terms and conditions.

C122	- day following the hospital admission assessment		46.15
C123	- second day following the hospital assessment		46.15
C124	- day of discharge		46.15
C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C268	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP35)	per visit	29.20

Attendance at maternal delivery

Attendance at maternal delivery requires constant attendance at the delivery of a baby expected to be at risk by a paediatrician, and includes an assessment of the newborn.

H267	Attendance at maternal delivery	63.45

Payment rule:
This service is not eligible for payment if any other service is rendered by the same physician at the time of the delivery unless the newborn is sick in which case a medical specific assessment (C263) is payable in addition to attendance at maternal delivery if rendered.

H261	Newborn care in hospital or home	57.90

Low birth weight newborn uncomplicated care

H262	- initial	per newborn	58.20
H263	- thereafter	per visit	17.75

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

W265	Consultation	142.80
W667	Neurodevelopmental consultation - subject to same conditions as A667	255.00
W565	Limited consultation	75.35
W266	Repeat consultation	75.35

Admission assessment

W562	- Type 1	58.20
W564	- Type 2	17.75
W567	- Type 3	30.70
W269	Annual physical examination	30.70

Subsequent visits (see General Preamble GP34)

Chronic care or convalescent hospital

W262	- first 4 subsequent visits per patient per month	per visit	29.20
W261	- additional subsequent visits per month (maximum 6 per patient per month)	per visit	13.40
W982	- palliative care (see General Preamble GP35)	per visit	29.20

Note:
In surgical cases requiring medical direction, standard in-hospital medical fees are to be claimed in addition to the surgical fee. This includes all operations on babies under one year of age, and all other older children who require medical supervision.

CONSULTATIONS AND VISITS

PHYSICAL MEDICINE & REHABILITATION (31)

GENERAL LISTINGS

A315	Consultation	142.80
A515	Limited consultation	75.35
A316	Repeat consultation	75.35
A313	Medical specific assessment	58.25
A310	Medical specific re-assessment	45.90
A311	Complex medical specific re-assessment	53.15
A318	Partial assessment	29.05
E078	- chronic disease assessment premium (see General Preamble GP21)	add 30%

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patient(s) in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP33. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

C315	Consultation	142.80
C515	Limited consultation	75.35
C316	Repeat consultation	75.35
C313	Medical specific assessment	58.25
C314	Medical specific re-assessment	45.90
C311	Complex medical specific re-assessment	53.15

Subsequent visits

C312	- first five weeks	per visit	29.20
C317	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C319	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 for terms and conditions.

C122	- day following the hospital admission assessment	46.15
C123	- second day following the hospital assessment	46.15
C124	- day of discharge	46.15

C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C318	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP35)	per visit	29.20

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

W515	Consultation	142.80
W310	Limited consultation	75.35
W516	Repeat consultation	75.35

Admission assessment

W512	- Type 1	58.20
W514	- Type 2	17.75
W517	- Type 3	30.70
W419	Annual physical examination	58.20
W314	General re-assessment of patient in nursing home*	17.75

Note:
*May only be claimed 6 months after Annual Health Examination (as per the *Nursing Homes Act*).

Subsequent visits (see General Preamble GP34)

	Chronic care or convalescent hospital		
W312	- first 4 subsequent visits per patient per month	per visit	29.20
W311	- additional subsequent visits (maximum of 6 per patient per month)	per visit	13.80
W982	- palliative care (see General Preamble GP35)	per visit	29.20
	Nursing home or home for the aged		
W313	- first 2 subsequent visits per patient per month	per visit	22.55
W318	- subsequent visits per month (maximum of 3 per patient per month)	per visit	13.80
W972	- palliative care (see General Preamble GP35)	per visit	29.20
W121	Additional visits due to intercurrent illness (see General Preamble GP34)	per visit	22.55

Team management in a Rehabilitation Unit

Team management in a Rehabilitation Unit active in-patient rehabilitation management from the initiation of rehabilitation care as it applies to fee codes H312, H317 and H319 means when this service is rendered by one physiatrist even if part of the service is rendered in an active treatment hospital and part is rendered in a rehabilitation unit, the weekly and monthly limitations under the following fee codes apply to the total rehabilitation care rendered. In other words, it is not possible to claim the maximum fees allowed under C312, C317 and C319 and then start claiming de novo under H312, H317 and H319 under the above circumstances.

H312	- first twelve weeks	per visit	29.20
H317	- from thirteenth to twenty-sixth week (maximum 3 per patient per week)	per visit	29.20
H319	- twenty-seventh week onwards (maximum 6 per patient per month)	per visit	29.20

Rehabilitation counselling

Rehabilitation counselling one or more persons. Unit means ½ hour or major part thereof - see General Preamble GP6, GP37 for definitions and time-keeping requirements.

H313	Rehabilitation counselling	51.70

Physiatric management

Physiatric management is the service rendered by physiatrists for regulation, management and supervision of the active, regular, and ongoing treatment of a patient in a rehabilitation department by physical or other (e.g. occupational, speech) therapists. The service also includes making arrangements for any related assessments, procedures or therapy and making arrangements for follow-up care as required.

K313	Physiatric management	6.10

Payment rules:

1. Physiatric management is not eligible for payment if any other service is rendered by the same physician on the same day to the same patient.
2. This service is only eligible for payment on days when rehabilitation services are provided to patients seen previously by the physiatrist for consultation or assessment.

[Commentary:

1. The fee is not meant as an administrative fee for supervising a department of rehabilitation.
2. This fee applies only to those patients who require and receive frequent attention by the physician during the course of rehabilitation with regard to rehabilitative services or physical therapy, occupational therapy, speech therapy and discharge planning.]

GENERAL LISTINGS

A085	Consultation	66.30
A935	Special surgical consultation (see General Preamble GP17)	127.50
A086	Repeat consultation	45.85
A083	Specific assessment	39.70
A084	Partial assessment	22.45

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patient(s) in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP33. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

C085	Consultation	66.30
C935	Special surgical consultation (see General Preamble GP17)	127.50
C086	Repeat consultation	45.85
C083	Specific assessment	39.70
C084	Specific re-assessment	25.15

Subsequent visits

C082	- first five weeks	per visit	29.20
C087	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C089	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 for terms and conditions.

C122	- day following the hospital admission assessment	46.15
C123	- second day following the hospital assessment	46.15
C124	- day of discharge	46.15

C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C088	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP35)	per visit	29.20

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

W085	Consultation	66.30
W086	Repeat consultation	45.85

CONSULTATIONS AND VISITS

RHEUMATOLOGY (48)

For Services not listed, refer to Internal Medicine Section.

GENERAL LISTINGS

A485	Consultation	127.50
A595	Limited consultation	75.35
A486	Repeat consultation	75.35
A483	Medical specific assessment	58.25
A484	Medical specific re-assessment	45.90
A481	Complex medical specific re-assessment	53.15
A488	Partial assessment	29.05
E078	- chronic disease assessment premium (see General Preamble GP21)	add 30%

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patient(s) in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP33. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

C485	Consultation	127.50
C595	Limited consultation	75.35
C486	Repeat consultation	75.35
C483	Medical specific assessment	58.25
C484	Medical specific re-assessment	45.90
C481	Complex medical specific re-assessment	53.15

Subsequent visits

C482	- first five weeks	per visit	29.20
C487	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C489	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 for terms and conditions.

C122	- day following the hospital admission assessment	46.15
C123	- second day following the hospital assessment	46.15
C124	- day of discharge	46.15
C121	Additional visits due to intercurrent illness (see General Preamble GP30) per visit	29.20
C488	Concurrent care per visit	29.20
C982	Palliative care (see General Preamble GP35) per visit	29.20

GENERAL LISTINGS

A355	Consultation*	66.30
A935	Special surgical consultation (see General Preamble GP17)	127.50
A356	Repeat consultation*	45.85
A353	Specific assessment*	39.70
A354	Partial assessment	22.45

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patient(s) in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP28 to GP33. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP44 to GP49.

C355	Consultation*	66.30
C935	Special surgical consultation (see General Preamble GP17)	127.50
C356	Repeat consultation*	45.85
C353	Specific assessment*	39.70
C354	Specific re-assessment	25.15

Subsequent visits

C352	- first five weeks	per visit	29.20
C357	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	29.20
C359	- after thirteenth week (maximum 6 per patient per month)	per visit	29.20

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP31 for terms and conditions.

C122	- day following the hospital admission assessment	46.15
C123	- second day following the hospital assessment	46.15
C124	- day of discharge	46.15

C121	Additional visits due to intercurrent illness (see General Preamble GP30)	per visit	29.20
C358	Concurrent care	per visit	29.20
C982	Palliative care (see General Preamble GP35)	per visit	29.20

CLINICAL PROCEDURES ASSOCIATED WITH DIAGNOSTIC RADIOLOGICAL EXAMINATIONS

MISCELLANEOUS PROCEDURES

		Spec	Anae
	Lymphangiogram		
# J010	- per side	75.55	
# J037	Mammary ductography	50.50	
# J011	Myelogram	75.55	5
# J038	- with supine views requiring removal and re-introduction of spinal needle ... add	21.20	
# J020	- with posterior fossa views ... add	21.20	
# J012	Nephrotomogram	-	5
# J060	Nephrostogram	21.20	
# J045	Percutaneous antegrade pyelogram	87.55	5
# J055	Percutaneous gastrostomy	160.60	
# J061	Percutaneous cecostomy	160.60	
# J062	Percutaneous cholecystostomy	160.60	
# J063	Percutaneous jejunostomy	186.30	
# J064	Exchange of drainage tubes, including supervision, imaging and hard copy film interpretation if any	52.15	
# J046	Percutaneous nephrostomy	160.60	5
# J041	Percutaneous removal of intravascular and intraureteric foreign bodies	211.95	IC
# J065	Dilation of non-vascular structures	18.25	5
# J059	Non-vascular stenting	72.90	
# J051	Percutaneous spinal cord puncture for syringogram	74.30	5
# J013	Percutaneous trans-hepatic cholangiogram	75.55	5
# J057	Transjugular intrahepatic portosystemic shunt (TIPS)	565.15	5
# J052	Positive contrast cisternogram	97.25	5
Z597	Intracavitary/intratumoural injections	70.75	5
# J039	Renal cyst puncture	87.55	5
# J018	Sialogram	32.60	5
# J007	Tomogram	-	5
# J028	Urethrogram, urethrocystogram, or intestinal conduit examination, cystogram	21.20	
# J029	Vasogram	58.35	5

Note:
Intubation of small intestine (see Z540 listed in Digestive System - Intestines (except rectum)).

CLINICAL PROCEDURES ASSOCIATED WITH DIAGNOSTIC RADIOLOGICAL EXAMINATIONS

NOT ALLOCATED

		Asst	Fee	Anae

Note:
Team benefits to include listed items. This does not include preliminary investigation of the case.

Haemodialysis

# R849	Initial and acute (includes both medical and surgical components)		621.35	6
# R850	Surgical component alone - insertion of Scribner shunt		313.25	6
G325	Medical component alone		308.00	
# G323	Acute, repeat - for the first 3 services		154.00	
# G083	Continuous venovenous haemodialysis - initial and acute (for the first 3 services)		369.65	
# G091	Continuous arteriovenous haemodialysis - initial and acute (for the first 3 services)		246.45	
# G085	Continuous venovenous haemofiltration - initial and acute (for the first 3 services)		369.65	
# G295	Continuous arteriovenous haemofiltration - initial and acute (for the first 3 services)		246.45	

Note:
Haemodialysis to include haemofiltration, haemoperfusion.

Continuous haemodiafiltration

# G082	Continuous venovenous haemodiafiltration - initial and acute (for the first 3 services)		431.20	
# G092	Continuous arteriovenous haemodiafiltration - initial and acute (for the first 3 services)		308.00	
# G094	Chronic, continuous haemodiafiltration		65.05	

Slow continuous ultrafiltration

# G090	Venovenous slow continuous ultrafiltration - initial and acute (for the first 3 services)		308.00	
# G294	Arteriovenous slow continuous ultrafiltration - initial and acute (for the first 3 services)		184.75	
# G096	Chronic, slow continuous ultrafiltration		65.05	

Revision of Scribner shunt

# Z450	- single		102.55	5
# Z451	- both		152.40	5
# Z452	De-clotting of Scribner shunt		93.60	
# R843	Removal of cannula or A.V. shunt		81.45	5
# R827	Creation of A.V. fistula	5	360.25	6

Note:
R827 - see also listing under Cardiovascular System, Veins - Repair.

# R841	Obliteration of A.V. fistula		82.55	5

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

DIALYSIS

		Fee	Anae
	Bypass graft for haemodialysis		
# R851	- synthetic	444.70	7
# R840	- autogenous vein	424.10	7
# R833	Ligation or removal of bypass graft	82.55	5
	Subclavian or external jugular catheter for haemodialysis		
# G324	- insertion	93.60	
# G336	- revision	15.35	
# R848	Dialysis cannula insertion under vision into central line (excluding percutaneous)	219.15	5
# G099	Percutaneous insertion of permanent jugular/femoral dialysis catheter (including subcutaneous positioning)	135.80	
# G327	Insertion of femoral catheter for dialysis	70.25	
# G312	Thrombolytic instillation into temporary and permanent percutaneous catheters	15.40	
	Peritoneal dialysis		
# G330	Acute (up to 48 hours) includes stylette cannula insertion (temporary)	199.55	
# G331	Repeat acute (up to 48 hours) - for the first 3 services	179.60	
# R852	Insertion of peritoneal cannula by laparotomy	186.95	6
# R885	Removal of peritoneal cannula by laparotomy	186.95	6
	Tenckhoff type peritoneal catheter		
# R853	- insertion, chronic by trocar	93.60	5
# R854	- removal	50.90	

		P1	P2
	Measurement of thermic effect of feeding		
	To follow 1 hour measurement of resting energy expenditure, subject is given a balanced test meal and then calorimetry measurements are taken for two hours, to include timed urine samples (2-3 hours) and urine nitrogen excretion measurements in a steady state condition, interpretation of results in context of patient's clinical status and written report.		
G516	Measurement of thermic effect of feeding	36.90	
	Oesophageal motility study(ies) with manometry		
G350	- standard, with physician in continuous attendance (P_1)	89.45	
G343	- interpretation only (P_2)		19.90
	Oesophageal acid perfusion test and/or provocative drug testing		
G353	- with physician in continuous attendance (P_1)	33.80	
G252	- interpretation only (P_2)		10.75
	Oesophageal pH study for reflux, with installation of acid		
G251	- standard, with physician in continuous attendance (P_1)	33.80	
G351	- with 24 hour monitoring		39.80
G346	- tracing interpretation only (P_2)		19.90
	Anal-rectal manometry		
G354	- with physician in continuous attendance (P_1)	45.30	
G253	- interpretation only (P_2)		10.65

		Fee
G254	Management of post liver transplant immunosuppression - in lieu of non-emergency hospital visits - (once per day to a maximum of two weeks) per visit	21.00
G349	Oesophageal tamponade (Blakemore bag) - insertion	45.30
	Gastric lavage	
+ G355	- diagnostic	9.60
G356	- therapeutic - with or without ice water lavage	33.80
# Z520	Change of gastrostomy tube	8.60
+ G357	Gastric secretion studies (Augmented Histamine or Histalog, or Pentagastrin) - procedure and supervision	19.55
G352	Biliary tract provocative test with cholecystokinin	9.60
# G322	Nasogastric intubation under general anaesthesia	9.60

		T	P
	Hydrogen breath test		
G167	- technical component	6.75	
G166	- professional component		10.45

			Fee
G367	Artificial insemination		25.55
G363	Cervical mucous penetration test		17.60
G361	Endometrial flushing		17.60
+ G364	Huhner's test		17.60
Z453	Tests of tubal patency e.g. Rubin's		20.10
G378	Insertion of intrauterine contraceptive device		25.50
E542	- when performed outside hospital	add	11.15
+ G362	Insertion of laminaria tent		6.25
E870	- when laminaria tent supplied by the physician	add	8.35
G334	Telephone supervisory fee for ovulation induction with human menopausal gonadotropins or gonadotropin-releasing hormone (not to be billed on same day as visit), to a maximum of 10 per cycle	per call	4.05

Papanicolaou Smear

+ G365	- periodic - maximum one per patient per 12 month period, excluding smears provided in conjunction with a consultation, repeat consultation, general or specific assessment or reassessment		6.75
+ G394	- additional - for follow-up of abnormal or inadequate smears		6.75
E430	- when papanicolaou smear is performed outside of hospital	add	11.15

Note:
The papanicolaou smear is included in the consultation, repeat consultation, general or specific assessment (or re-assessment), annual health or routine post-natal visit when a pelvic examination is a normal part of the foregoing services. However, the add-on code E430 can be billed in addition to these services when a papanicolaou smear is performed outside hospital.

Z462	Insertion of Norplant		43.50
Z463	Removal of Norplant		65.30
# G397	Medical management of ectopic pregnancy - includes administration of cyto-toxic medication(s) and routine follow-up visits for supervision within a period of seven days		67.75

Pessary

G398	Medical management of prolapse - initial pessary fitting or re-fitting as required. This service is in addition to any applicable consultation or assessment. Maximum one per patient per 12 month period		41.90

[Commentary:
G398 cannot be billed for routine follow-up insertion of a pessary as that service is included as an element of the assessment or consultation.]

OBSTETRICS

OBSTETRICAL ANAESTHESIA

		Asst	Surg	Anae
# P013	Obstetrical anaesthesia		-	5
	Continuous conduction anaesthesia - see General Preamble GP56			
# P014	(a) introduction of catheter for analgesia including first dose		-	6
# P015	(b) maintenance and/or supervision (one unit for each ½ hour to a maximum of 6 units)		-	
# P016	(c) maintenance of obstetrical epidural anaesthesia (one unit for each ½ hour to a maximum of 12)		-	
# E100C	(d) attendance at delivery - per ¼ hour - time units		-	

Note:
When P015 and P016 are claimed same patient same hospital same day, the amount payable for P015 is nil.

G224	Pudendal, brachial plexus block (bilateral) - (see General Preamble GP58)		15.55	

OBSTETRICS

HIGH RISK PREGNANCIES

		Asst	Surg	Anae
# Z776	Fetal blood sampling		40.80	
# Z773	Fetoscopy (may include fetal blood sample, cell harvest or amniocentesis or cordocentesis)		165.40	
# Z734	Double set up examination to rule out placenta previa, or trial of forceps - failed leading to caesarean section (same physician)		58.00	
# P030	Cervical ripening using topical, oral or mechanical agents, maximum once per pregnancy. Payable in conjunction with P022 and P023		58.60	

Note:
Cervical ripening rendered to same patient same day by same physician as a consultation or visit is an insured service payable at nil.

# P022	Oxytocin infusion for induction of labour - see Obstetrics Preamble paragraph 9		67.75	
# P023	Oxytocin infusion for stimulation of desultory labour		67.75	

Non stress test

Payable only for high risk pregnancies - must include interpretation of trace, discussion with patient and providing a written report to be retained in the patient's permanent medical record and may include application of the fetal monitor and data acquisition. Maximum one per patient per day.

# P025	Non stress test		9.65	
# Z721	Pharmacological suppression of premature labour by I.V. therapy to be claimed once per physician after 3 hours of supervision in same institution		67.75	
# Z775	Pharmacological management of P.I.H. and toxemia by I.V therapy to be billed once per patient, per pregnancy		67.75	
# Z778	Amniocentesis - diagnostic or genetic		102.00	
# Z779	Chorionic villus sampling		153.00	
# P031	Suture of incompetent cervix in pregnancy cervical cerclage - any technique	5	145.10	5
UVC	Elective removal of Shirodkar suture		visit.fee	
# P034	Uterine inversion, manual replacements		125.75	5
# Z777	Breech presentation - external cephalic version with or without tocolysis - to be claimed in hospital after 35 weeks, once per pregnancy		60.35	

Note:
Listings for ectopic pregnancy, hysterotomy, abortion and postpartum tubal interruption are listed under the Female Genital System - Corpus Uteri.

SURGICAL PREAMBLE

PREAMBLE

SPECIFIC ELEMENTS

In addition to the common elements, all surgical services include the following specific elements.

A. Supervising the preparation of and/or preparing the patient for the procedure(s).

B. Performing the procedure(s), by any method, or assisting another physician in the performance of the procedure and carrying out appropriate recovery room procedures, being responsible for the transfer of the patient to the recovery room, ongoing monitoring and detention during the immediate post-operative and recovery period.

C. Making arrangements for any related assessments or procedures, including obtaining any specimens from the patient and interpreting the results where appropriate.

D. Where indicated, making or supervising the making of arrangements for follow-up care, and post-procedure monitoring of the patient's condition, including intervening, until the first post-operative visit.

E. Discussion with, providing any advice and information, including prescribing therapy, to the patient or patient's representative(s), whether by telephone or otherwise, on matters related to the service.

F. Providing premises, equipment, supplies and personnel for the specific elements:

a. for services not identified with prefix #, for all elements;

or

b. for services identified with prefix #, for any aspect(s) of A, C, D and E that is(are) performed in a place other than the place in which the surgical procedure(s) is performed.

SURGICAL SERVICES WHICH ARE NOT LISTED AS A "Z" CODE

In addition to the above, the fee for this service includes the following:

1. **Pre-operative Care and Visits**

   Pre-operative hospital visits which take place 1 or 2 days prior to surgery.

2. **Post-operative Care and Visits**

   Post-operative care and visits associated with the procedure for up to two weeks post-operatively, and making arrangements for discharge, to a hospital in-patient except for:

   a. the first and second post-operative visits in hospital (payable at the specialty specific subsequent visit fee);

   and

   b. subsequent visit by the Most Responsible Physician (MRP) - day of discharge (C124).

The specific elements for pre- and post-operative visits are those for assessments.

[Commentary:
C122, C123 (subsequent visit by the MRP - day following, or second day following the hospital admission assessment) are not payable to the surgeon for visits rendered either 1 or 2 days prior to surgery or for visits rendered to hospital in-patients post-operatively.]

SURGICAL PREAMBLE

PREAMBLE

OTHER TERMS AND DEFINITIONS

FOR DEFINITION OF THE ROLE OF THE SURGICAL ASSISTANT - SEE GENERAL PREAMBLE GP51.

FOR DEFINITION OF THE ROLES OF THE ANAESTHESIOLOGIST - SEE GENERAL PREAMBLE GP54.

With the exception of the listings in the "Consultations and Visits" section, all references to surgeon in this schedule are references to any physician performing the surgical procedure.

1. If the surgeon is required to perform a service(s) not usually associated with the original surgical procedure, he/she may claim for these on a fee-for-service basis.

   If special visits to hospital are required at any time post-operatively, the surgeon may claim the minimum special visit premiums even if the basic hospital visit fees may not be claimed (under these circumstances the hospital visits should be claimed on an N/C ($00.00) basis).

   The surgical benefit as noted above does not include the major pre-operative visit - i.e. the consultation or assessment fee which may be claimed when the decision to operate is made and the operation is scheduled, regardless of the time interval between the major pre-operative visit and surgery.

   The hospital or day care admission assessment (consultation, repeat consultation, general or specific assessment or re-assessment, partial assessment) may not be claimed by the surgeon unless it happens to be the major pre-operative visit as defined above.

   Routine subsequent hospital visits may be claimed for visits rendered more than two days prior to surgery. Other visits (excluding admission assessments) prior to admission may be claimed for in addition to the surgical fee.

   Because the number of hospital visits is limited to three per week after the fifth week of hospitalization and six per month after the thirteenth week of hospitalization, the starting point for calculating the number of hospital visits is based on the date of admission if the operating surgeon has admitted the patient or the date of referral if the patient has been referred to the operating surgeon while in hospital.

   The listed benefit for a procedure normally includes repair of any iatrogenic complications occurring during the course of the surgery performed by the same surgeon. Other major interventions should be handled on an individual basis. The surgical benefit includes the generally accepted surgical components of the procedure.

2. When a physician makes a special visit to perform a non-elective surgical procedure, he/she may claim the following benefits for procedures commencing:

   a. 07:00h -17:00h - Monday to Friday
   A consultation (if the case is referred) or the appropriate assessment, the appropriate special visit premium plus the procedural benefit.

   b. 17:00h - 07:00h - Any night or on Saturdays/Sundays or Holidays
   A consultation or assessment, the appropriate special visit premium, the procedural benefit plus the surgical premium E409 or E410.

   (see General Preamble GP44 to GP49 and GP60).

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

		Asst	Surg	Anae
	INCISION			
	Abscess or haematoma - Local anaesthetic			
	- subcutaneous			
Z101	- one	nil	20.10	
Z173	- two		30.35	
Z174	- three or more		40.80	
Z104	- perianal		20.10	
Z106	- ischiorectal or pilonidal		44.35	
Z103	- palmar or plantar spaces		44.35	
E542	- when performed outside hospital	add	11.15	
	Abscess or haematoma - General anaesthetic			
	- subcutaneous			
# Z102	- one		44.35	5
# Z172	- two or more		66.60	5
# Z105	- perianal		44.35	5
# Z107	- ischiorectal or pilonidal		72.00	5
# Z108	- palmar or plantar spaces		72.00	5
	Foreign body removal			
Z114	- local anaesthetic		18.80	
E542	- when performed outside hospital	add	11.15	
# Z115	- general anaesthetic	5	88.80	5
# Z100	- complicated (see General Preamble GP12)	5	I.C	5
# Z227	Intramuscular abscess or haematoma		101.65	5
Z118	Aspiration of superficial lump for cytology		28.25	
	Biopsy(ies)			
Z116	- any method, when sutures are used		14.70	
E542	- when performed outside hospital	add	11.15	
Z113	- any method, when sutures are not used		14.70	

Note:
Z116 may be allowed more than once on an IC basis if medically necessary (in order to make a diagnosis or to plan treatment) to biopsy more than one lesion or to obtain a second biopsy from an extensive lesion. If claimed, may be allowed with chemical treatment of lesion (code Z117).

# Z155	Biopsy(ies) - extensive, complicated or requiring general anaesthetic when sole procedure (see General Preamble GP12)		I.C	I.C
# Z245	Biopsy for malignant hyperthermia, three or more		152.85	10

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

			Asst	Surg	Anae
	EXCISION (WITH OR WITHOUT BIOPSY)				
	LESIONS - SINGLE OR MULTIPLE SITES				
	Note:				
	1. Tattoo removal - (see Appendix D Surface Pathology Section 3).				
	2. Removal of any lesions (e.g. keratosis, nevi) for cosmetic purposes and not for any clinical suspicion of disease or malignancy is not an insured service.				
	Group 1 - verruca, keratosis, pyogenic granuloma				
	(see Appendix D Surface Pathology)				
	Removal by excision and suture				
Z156	- single lesion		14.80	5	
Z157	- two lesions		22.15	5	
Z158	- three or more lesions		36.90	5	
E542	- when performed outside hospital	add	11.15		
	Removal by electrocoagulation and/or curetting				
Z159	- single lesion		10.55	5	
Z160	- two lesions		15.85	5	
Z161	- three or more lesions		26.20	5	
	Group 2 - nevus				
	(see Appendix D Surface Pathology, Section 4)				
	Removal by excision and suture				
Z162	- single lesion		14.80	5	
Z163	- two lesions		22.15	5	
Z164	- three or more lesions		36.90	5	
E542	- when performed outside hospital	add	11.15		
# Z165	Congenital (extensive) (see General Preamble GP12)		I.C	I.C	
	Group 3 - plantar verruca				
	Removal by electrocoagulation and/or curetting				
Z169	- single lesion		20.10	5	
Z170	- two lesions		30.30	5	
Z171	- three or more lesions		59.95	5	

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

			Asst	Surg	Anae
	Group 4 - cyst, haemangioma, lipoma				
	Face or neck - Local anaesthetic				
Z122	- single lesion		nil	32.20	
Z123	- two lesions			47.60	
Z124	- three or more lesions			65.35	
E542	- when performed outside hospital	add		11.15	
	Face or neck - General anaesthetic				
# Z145	- single lesion		5	65.35	5
# Z146	- two lesions		5	98.55	5
# Z147	- three or more lesions		5	131.10	5
# Z148	- extensive or massive (see General Preamble GP12)		5	I.C	5
	Other areas - Local anaesthetic				
Z125	- single lesion		nil	27.05	
Z126	- two lesions			38.15	
Z127	- three or more lesions			50.00	
E542	- when performed outside hospital	add		11.15	
	Other areas - General anaesthetic				
# Z149	- single lesion		5	50.00	5
# Z150	- two lesions		5	65.55	5
# Z151	- three or more lesions		5	98.55	5
# Z152	- extensive or massive (see General Preamble GP12)		5	I.C	5
	Group 5 - other lesions				
Z096	Lipoma - 5 to 10 cm		5	73.75	5
E542	- when performed outside hospital	add		11.15	
# Z097	Lipoma - over 10 cm		5	110.75	5
# R034	Congenital dermoid cyst adult		5	124.40	5
# R043	- infant or child		5	201.10	5
# R042	- midline, e.g. nasal		5	272.80	5
# R037	Giant cell tumour		5	151.85	5
	Pilonidal cyst				
# R035	- simple excision or marsupialization		nil	183.30	5
# R036	- excision and skin shift		5	248.80	5
	Inguinal, perineal or axillary skin and sweat glands for hyperhydrosis and/or hydradenitis				
# R059	- unilateral		5	248.80	5
# R060	- with skin graft(s) or rotation flap(s)		5	377.90	6

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

		Asst	Surg	Anae

MALIGNANT LESIONS INCLUDING BIOPSY OF EACH LESION - SINGLE OR MULTIPLE SITES

The amount payable for any service rendered in respect of a malignant lesion is reduced to nil if the pathologist's report of his or her examination of the tissue specimen is not retained in the patient's record.

Note:
A pre-malignant lesion is not a malignant lesion for the purposes of payment.

Face or neck

Simple excision

R048	- single lesion		5	70.90	5
R049	- two lesions		5	116.50	5
R050	- three or more lesions		5	233.00	5
E542	- when performed outside hospital	add		11.15	

Other areas

Simple excision

R094	- single lesion		5	58.15	5
R040	- two lesions		5	95.70	5
R041	- three or more lesions		5	191.40	5
E542	- when performed outside hospital	add		11.15	

Malignant melanoma

R010	- wide excision in any area and must include > 1 cm margins and layered closure		5	124.10	5
# E540	- if excision is performed in hospital for tumour free margin with frozen section, to excision or repair fees	add 25%			

Note:
When excision of benign or malignant lesions are corrected by advancement, rotation, transposition, Z-plasty, flap or graft, claim appropriate benefit listed under Repair Section instead of foregoing excision benefits.

Face or neck

Curettage, electrodesiccation or cryosurgery

R018	- single lesion		5	68.55	5
R019	- two lesions		5	112.90	5
R020	- three or more lesions		5	225.75	5

Other areas

Curettage, electrodesiccation or cryosurgery

R031	- single lesion		5	55.05	5
R032	- two lesions		5	90.70	5
R033	- three or more lesions		5	181.55	5

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

		Asst	Surg	Anae
# R051	Laser surgery on Group 1-5 and malignant lesions (see General Preamble GP12)		I.C	I.C

Note:
Physicians treating vascular ectasias by laser may obtain from their Ministry of Health and Long-Term Care Medical Consultant the current Ministry policy regarding conditions approved for coverage under the Plan.

MOHS' SURGERY

Note:

1. R081 and E524 are billable only for complicated epithelial cancer where 2 or more previous treatments have failed or where the cancer is in an anatomical area where tissue preservation is of the utmost importance (e.g. ear, nose, eyelids and mouth).
2. R081 and E524 are billable only once whether or not excision of the lesion extends to the subsequent day.
3. Closure of the resulting defect by undermining and advancement flaps is included in the above fees. If more complicated closure is medically necessary, bill as an extra under appropriate listings for skin grafts.
4. The preparation of slides must be done or supervised by the Mohs' surgeon and all tissue section slides must be personally microscopically reviewed and interpreted personally by the physician claiming Mohs' surgery.
5. Where a physician submits a claim for performing Mohs' surgery to four patients on any one day, the amount payable for any other Mohs' surgery performed by the same physician on the same day is reduced to nil.

# R081	Initial cut, including debulking		265.45	5
# E524	- one or more additional cuts	add	233.55	

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

		Asst	Surg	Anae
	REPAIR			
	Debridement and dressing			
UVC	- minor		visit fee	
# Z153	- major (not to be claimed in addition to Z176)		14.05	
# Z144	- requiring general anaesthetic	5	56.75	5
# R082	- extensive (see General Preamble GP12)	5	I.C	5

Note:
Not to be claimed in addition to any surgical procedure unless complications require such care in excess of the usual post-operative care.

Burns

Note:
For burn care requiring anaesthetists' and assistants' services, the following fees apply.

# R030	Minor burns - up to 15%	5	-	5
# R038	Moderate burns - 16% to 30%	6		10
# R039	Major burns - more than 30%	8	-	15

Resuscitation - Major Burn, Initial Care

These fees apply to the service of being in constant or periodic attendance during a 24 hour period following a major burn, to provide all aspects of resuscitation to the patient. This follows the initial assessment, and includes such subsequent assessments as may be indicated. The specific elements are those of an assessment, including ongoing monitoring of the patient's condition, and intervening as appropriate (see General Preamble GP15). Instead of element H, the assessment includes, providing premises, equipment, supplies and personnel for any aspects of the specific elements that is(are) performed in a place other than the place in which the assessment is performed. Separately billable interventions may be claimed in addition to these fees.

# Z180	- first 24 hours	106.25
# Z181	- continuing care (up to 3 days), per day	53.10

Debridement and excision

# R660	- hand, each digit	28.90
# R661	- dorsum palm - each	47.95
# R662	- nose, cheek, lip, ear, forehead, scalp, neck, eyelid - each	28.90
# R637	Debridement and excision, per % of total body treated other than hand, head or neck	29.65

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

		Asst	Surg	Anae
	Grafting of burn, per % of total body treated			
# R638	Other than hand, head or neck		49.25	
	Hand			
# R663	- each digit		57.60	
	Palm, dorsum			
# R664	- each		115.20	
	Nose, lip(s)			
# R665	- each		192.00	
	Cheek(s), forehead			
# R666	- each		192.00	
# R667	Ear		192.00	
# R668	Eyelid		192.00	
	Scalp			
# R669	- less than 10%		96.05	
# R670	- up to 50%		251.55	
# R671	- over 50%		323.60	
	Neck			
# R672	- less than 10%		96.05	
# R673	- up to 50%		241.85	
# R674	- over 50%		313.95	
	Skin allograft procurement			
R690	- for banking purposes, per % of total body harvested, other than hand, head or neck	7	17.25	7

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

		Asst	Surg	Anae
	Suture of lacerations			
	Note: Wound closure via tissue adhesives (such as cyanoacrylate) is payable at 50% of the appropriate fee.			
Z176	- up to 5 cm		14.80	5
Z154	- up to 5 cm if on face and/or requires tying of bleeders and/or closure in layers		35.90	5
Z175	- 5.1 to 10 cm		35.90	5
Z177	- 5.1 to 10 cm if on face and/or requires tying of bleeders and/or closure in layers		71.30	5
Z179	- 10.1 to 15 cm		50.40	5
Z190	- 10.1 to 15 cm if on face and/or requires tying of bleeders and/or closure in layers		101.45	5
Z191	- more than 15.1 cm - other than face		77.30	5
Z192	- more than 15.1 cm - on face		154.95	5
E530	- if inhalation general anaesthesia (other than 50% N_2O/O_2 mixture) is used, when suture of laceration is sole procedure ... add		50.40	
E531	- if extensive debridement is required (see General Preamble GP12) ... add		I.C	
E542	- when performed outside hospital ... add		11.15	
R024	Acute laceration earlobe, unilateral		100.65	
UVC	Removal of sutures only		visit.fee	
	Note: The above benefits include the use of sutures, local anaesthetic, tetanus toxoid and routine observation.			
	Muscle repair			
# R525	Simple muscle repair(s) to include repair of involved skin	5	88.60	5
# R528	Complex (see General Preamble GP12)	5	I.C	6

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

		Asst	Surg	Anae

PREAMBLE TO SKIN FLAPS AND GRAFTS

The amount payable will depend on the size and location of the area grafted and the type of graft. Additional procedures other than the skin grafting are payable in addition to the skin flap or grafts, e.g. tendon grafts, inlay grafts, etc.

E540 - payable once per lesion for excision of tumour free with frozen section, to first flap or graft procedure . . add 25%

SKIN FLAPS

A. Advancement flaps

Note:
To include undermining of more than 2.5 cm per side. Is intended to include excision of a lesion if this is technique of closure.

	Defect 2.1 to 5 cm			
# R011	- face, neck or scalp	5	89.85	5
# R002	- other areas	5	67.40	5
	Defect 5.1 to 10 cm			
# R012	- face, neck or scalp	5	247.15	5
# R003	- other areas	5	161.75	5
# R004	Defect more than 10 cm such as thoracic abdominal flap	5	242.70	6

B. Rotations, transpositions, Z-plasties

Note:
Includes undermining but will depend on the site and size.

	Defect less than 2 cm average diameter			
# R045	- face, neck or scalp	5	199.55	5
# R072	- other areas	5	133.40	5
	Defect 2.1 to 5 cm average diameter			
# R046	- face, neck or scalp	5	335.15	5
# R075	- other areas	5	223.35	5
	Defect 5.1 to 10 cm average diameter			
# R047	- face, neck or scalp	5	477.45	5
# R073	- other areas	5	318.45	5
	Defect more than 10 cm average diameter			
# R076	- face, neck or scalp	5	709.90	5
# R074	- other areas	5	477.85	5

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

		Asst	Surg	Anae
	C. Pedicle flaps			
# R079	Small, e.g. cross finger	5	133.40	5
# R077	- each subsequent stage	5	98.90	5
# R070	Intermediate, e.g. cervical finger	5	293.75	5
# R071	- each subsequent stage	5	223.35	5
# R080	Large, e.g. cross leg, deltopectoral, forehead	5	416.30	6
# R078	- each subsequent stage	5	311.45	6
# E069	- preparation of a contracted recipient site, to R070 and R080 ... add		134.75	
# R103	Delay of tube or pedicle		63.15	5
# R101	Delay, intermediate flap	5	132.45	5
# R100	Delay, major flap	5	291.90	5
	D. Myocutaneous, myogenous or fascia-cutaneous flaps			
	Note: To include closure by any means.			
# R005	Sterno-mastoid, tensor fascia lata, gluteus maximus, gracilis, sartorius, rectus femoris, gastrocnemius (medial and lateral), trapezius	5	470.90	5
# R006	Pectoralis major, latissimus dorsi, unilateral rectus abdominus	5	734.95	6
# R008	Lower transverse rectus abdominus flap	6	984.55	8
	Repair of abdominal defect			
# Z195	- same surgeon		201.10	
# Z196	- different surgeon		377.65	
# R009	Myocutaneous - osseous flaps e.g. pectoralis major myocutaneous flap with rib graft, trapezius flap with scapula spine	6	783.40	8
# R007	Other - (see General Preamble GP12)	I.C	I.C	I.C

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

SKIN GRAFTS

		Asst	Surg	Anae
	A. Split thickness grafts (for burn grafts see pages M6 & M7).			
# R084	Very minor, very small areas, e.g. trauma		92.30	5
# R085	Minor, medium sized areas, e.g. small or skin ulcer, breast, etc	5	140.25	5
# R086	Intermediate, large areas, e.g. trunk, arms, legs	5	259.10	5
# R087	Major, complex areas, e.g. face, neck, hands	5	388.00	5
# R088	Extensive major, very large area(s)	5	567.95	6

Note:
The Medical Consultant may be requested to determine appropriateness of code claimed relative to size.

	B. Full thickness grafts			
# R092	Minor - less than 1 cm average diameter		93.30	5
# R093	Intermediate - 1 cm to 5 cm average diameter	5	143.10	5
# R083	Major - over 5 cm	5	224.10	5
# R091	Complex - eyelid, nose, lip, face	5	210.20	5

Note:
R092, R093, R083, R091 - The Medical Consultant may be requested to determine appropriateness of codes claimed relative to size of graft.

# R057	Appendage or tissue re-vascularization involving microanastomosis with or without micro neuroanastomosis (see General Preamble GP12)	I.C	I.C	I.C
# R058	Revision of above (see General Preamble GP12)	I.C	I.C	I.C

Stasis ulcer

# R847	- with skin graft - per leg	5	195.85	5
# R845	- multiple ligation and skin graft - per leg	5	341.55	5

Neurovascular island transfer

# R061	Minor, e.g. finger tip	5	140.25	5
# R062	Intermediate, e.g. finger to thumb transfer	5	259.20	5
# R063	Major, e.g. foot to heel	5	430.85	6

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

FREE ISLAND FLAPS

Note:
When excision of the lesion and preparation of the recipient site are carried out by different surgeons, the preparation fees should be reduced by 15%.

		Asst	Surg	Anae
# R013	Free jejunum artery and vein for transplantation	10	322.70	10
# R014	Preparation of microvascular recipient site for free jejunum artery and vein	10	881.75	10
# R016	Preparation of microvascular recipient site for jejunum artery and vein immediately following ablative surgery, and when recipient vessels are in site of the ablation	10	519.00	10
# R015	Transplantation of free jejunum artery and vein with microvascular anastomosis	10	881.75	10
# R064	Elevation of free island skin and subcutaneous flap and closure of defect	10	832.95	10
# R065	Preparation of microvascular recipient site for free island skin subcutaneous flap	10	881.75	10
# R055	Preparation of microvascular recipient site for free island flap and subcutaneous flap immediately following ablative surgery and when recipient vessels are in site of the ablation	10	519.00	10
# R066	Transplantation of free island skin and subcutaneous flap with microvascular anastomosis(es)	10	881.75	10
# R067	Elevation of innervated free island skin and subcutaneous flap and closure of defect	10	979.25	10
# R068	Preparation of microvascular recipient site for innervated free island skin and subcutaneous flap	10	979.25	10
# R056	Preparation of microvascular recipient site for innervated free island skin and subcutaneous flap immediately following ablative surgery and when recipient vessels are in the site of ablation	10	576.35	10
# R069	Transplantation of innervated free island skin and subcutaneous flap with microvascular anastomosis(es) and nerve repair	10	915.80	10
# R125	Elevation of free island skin and muscle flap and closure of defect	10	832.95	10
# R126	Preparation of microvascular recipient site for free island skin and muscle flap	10	881.75	10
# R122	Preparation of microvascular recipient site for free island skin and muscle flap immediately following ablative surgery and when recipient vessels are in the site of the ablation	10	519.00	10
# R127	Transplantation of free island skin and muscle flap with microvascular anastomosis(es)	10	832.95	10

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

FREE ISLAND FLAPS

		Asst	Surg	Anae
# R128	Elevation of free island muscle flap with tendon and nerve, and closure of defect	10	1127.15	10
# R129	Preparation of microvascular recipient site for muscle, tendon and nerve anastomosis(es)	10	1126.85	10
# R123	Preparation of microvascular recipient site for muscle, tendon and nerve anastomosis(es) immediately following ablative surgery and when recipient vessels are in site of the ablation	10	663.25	10
# R130	Transplantation of free island muscle flap with tendon, nerve and microvascular anastomosis(es)	10	1127.15	10
# R131	Elevation of free island bone flap and closure of defect	10	832.95	10
# R132	Preparation of microvascular recipient site for free island bone flap	10	881.75	10
# R124	Preparation of microvascular recipient site for free island bone flap immediately following ablative surgery and when recipient vessels are in the site of the ablation	10	519.00	10
# R133	Transplantation of free island bone flap with microvascular anastomosis(es) and bone fixation	10	979.25	10
# R134	Elevation of free island skin and bone flap and closure of defect	10	998.65	10
# R135	Preparation of microvascular recipient site for free island skin and bone flap	10	998.65	10
# R140	Preparation of microvascular recipient site for free island skin and bone flap immediately following ablative surgery and when recipient vessels are in the site of the ablation	10	587.70	10
# R136	Transplantation of free island skin and bone flap with microvascular anastomosis(es) and bone fixation	10	998.65	10
# R137	Elevation of free toe or finger and closure of defect	10	998.65	10
# R138	Preparation of microvascular recipient site for free toe or finger transplant	10	998.65	10
# R141	Preparation of microvascular recipient site for free toe or finger transplant immediately following ablative surgery and when recipient vessels are in the site of the ablation	10	587.70	10
# R139	Transplantation of free island toe or finger with microvascular anastomosis(es) and tendon nerve and bone repair	10	1175.00	10
# R025	Revision of free island flaps (see General Preamble GP12)	10	I.C	10
# R106	Skin flaps and grafts - other than listed above (see General Preamble GP12)	I.C	I.C	I.C

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

		Asst	Surg	Anae
	FINGER OR TOE-NAIL			
Z110	Extensive debridement of onychogryphotic nail involving removal of multiple laminae		17.45	
	Simple, partial or complete, nail plate excision requiring anaesthesia			
Z128	- one		23.80	5
Z129	- multiple		35.70	5
E542	- when performed outside hospital ... add		11.15	
	Radical, including destruction of nail bed			
# Z130	- one	nil	62.75	5
# Z131	- multiple		82.65	5
E542	- when performed outside hospital ... add		11.15	
	Chemical and/or cryotherapy treatment of minor skin lesions			
Z117	- one or more lesions, per treatment		11.05	

Note:
See Appendix D Surface Pathology

WEBBED FINGERS AND TOES

# R089	Webbed fingers - one web space	5	269.55	5
# R090	Webbed toes - one web space	5	123.80	5

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

SCAR REVISION - ANY METHOD OF CLOSURE

		Asst	Surg	Anae
Up to 2.5 cm				
R021	- face or neck	5	115.60	5
R026	- other areas	5	77.35	5
2.6 cm to 5 cm				
R022	- face or neck	5	194.85	5
R027	- other areas	5	130.10	5
5.1 cm to 10 cm				
R023	- face or neck	5	277.90	5
R028	- other areas	5	185.60	5
Greater than 10 cm				
R017	- face or neck	5	417.05	6
R029	- other areas	5	288.20	6

Note:

1. Authorization is required for all scar revisions in areas other than the face or neck (see Appendix D).
2. Revision of post-infection scarring of face must be claimed on an "I.C" basis - maximum payable will be as equated to R023.

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

PLASTIC SURGERY PROCEDURES

		Asst	Surg	Anae
	The setting of benefits covering the various procedures of plastic surgery is a very difficult problem. Since many procedures are divided into stages which have to be considered in assessing a fee, it is felt that all such plastic surgical procedures should be classed by the responsible specialist as very minor, intermediate, major or extensive major. Benefits should be claimed according to procedures set forth in the tariff, except in cases which are difficult to define, in which case "I.C" should be the basis of the claim.			
	The minimum benefit for each would be as follows:			
# R150	Very minor		92.30	5
# R151	Minor	5	140.25	5
# R152	Intermediate	5	259.20	5
# R153	Major	5	388.00	5
# R154	Extensive major	5	568.95	6

Note:

1. Descriptive details of procedure (e.g. operative report) should be submitted with claims for codes R150 - R154 for professional assessment.
2. Taking of skin by a surgeon for grafting by an Oral Surgeon - claim as R150.

# Z132	Insertion of tissue expander	5	196.70	5
# E527	- additional expander, same incision — add		58.95	
# E528	- additional expander, different incision — add		167.30	

Note:
Authorization may be required from the Ministry of Health and Long-Term Care (e.g. for scars of legs, etc.).

Removal tissue expander injection port when sole procedure

# Z094	- general anaesthetic	5	75.45	5
# Z095	- local anaesthetic		37.70	
Z137	Percutaneous inflation of first tissue expander		23.05	
E541	- each additional expander (to a maximum of 3)		11.55	
# Z138	Replacement of tissue expander by permanent prosthesis		195.85	5

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

OPERATIONS ON THE BREAST

		Asst	Surg	Anae
	INCISION			
	Needle biopsy			
Z141	- one or more	nil	25.15	
E542	- when performed outside hospital ... add		11.15	
Z143	- large core breast biopsy - (14 gauge or larger bore needle)		107.05	
	Aspiration of cyst			
Z139	- one or more	nil	25.15	
	Drainage of intramammary abscess or haematoma			
# Z140	Single or multiloculated - local anaesthetic		25.15	
# Z740	Single or multiloculated - general anaesthetic		63.05	5
	EXCISION			
# R107	Tumour or tissue for diagnostic biopsy and/or treatment, e.g. carcinoma, fibroadenoma or fibrocystic disease (single or multiple - same breast)	5	137.05	5
# E525	- after mammographic wire localization ... add		41.55	
# R111	Partial mastectomy or wedge resection for treatment of breast disease with or without biopsy, e.g. carcinoma or extensive fibrocystic disease	5	269.40	5
# E525	- after mammographic wire localization ... add		41.55	
# E546	- with axillary node dissection up to the level of the axillary vein ... add		315.95	2
# E505	- with limited axillary node sampling ... add		178.05	1
# R105	Partial mastectomy plus radical node dissection	5	658.15	6
# E525	- after mammographic wire localization ... add		41.55	
	Mastectomy - female (with or without biopsy)			
# R108	- simple	5	273.95	5
# R117	- subcutaneous with nipple preservation	5	273.95	5
	Note: R117 - include skin grafts if required.			
# R109	Mastectomy, radical or modified radical (with or without biopsy)	5	658.15	6
	Note: R109 - allow skin graft in addition if claimed.			

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

OPERATIONS ON THE BREAST

		Asst	Surg	Anae
	Mastectomy - Male (benign)			
	Unilateral - for treatment of adolescent gynecomastia, gynecomastia secondary to endocrine or genetic disorders (e.g. Klinefelter's Syndrome) or chemotherapy. Prior approval is not required. Removal of male breast fat tissue by liposuction is not an insured service.			
# R146	- simple	5	177.50	5
# R147	- subcutaneous with nipple preservation	5	273.95	5
	Mastectomy - male			
	Unilateral - for treatment of pathological male breast disease (with or without biopsy), e.g. carcinoma			
# R148	- simple	5	273.95	5
# R149	- subcutaneous with nipple preservation	5	273.95	5
	REPAIR			
	Post-mastectomy breast reconstruction			
# R119	Breast mound creation by prosthesis and/or soft tissue	5	304.10	5
# R118	Breast skin reconstruction by local flaps or grafts	5	405.60	5
# E529	- with breast mound creation by prosthesis and/or soft tissue ... add		102.45	
# E526	- with contralateral balancing mastopexy or reduction, to include nipple transplantation ... add		283.35	
# R114	Revision of breast mound	5	230.30	5
	Note: By myocutaneous flaps - see codes R005 - R009.			
# R113	Nipple-areola preservation and tissue-banking	5	117.55	5
# R121	Re-implantation of tissue-banked nipple-areola	5	137.15	5
# R120	Nipple-areola reconstruction by grafts	5	230.30	5
# R110	Reduction mammoplasty (female, to include nipple transplantation or grafting) - unilateral	5	472.15	7
# R112	Augmentation mammoplasty - unilateral	5	200.40	5
	Note: R110 - R112 - Claims for these procedures may require Ministry of Health and Long-Term Care authorization (see Surgical Preamble SP5; also, Appendix D).			
# Z142	Removal of breast prosthesis	5	79.10	5
	Breast capsulotomy closed			
# Z133	- no anaesthetic		12.70	
# Z134	- general anaesthetic	5	79.10	5
# Z135	Open capsulotomy with or without replacement of breast prosthesis	5	195.95	5
# Z182	Breast capsulectomy	5	255.05	5
# R006	Myocutaneous flaps - pectoralis major, latissimus dorsi, unilateral rectus abdominus	5	734.95	6
	Note: Correction of inverted nipple(s) is not an insured service.			

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

PREAMBLE

A. Corrective splints must be corrective to qualify for a benefit as such. The corrective splint listings are not applicable to simple immobilization such as with a Jones bandage or metal finger splint following soft tissue injury.

B. The removal of a wire or pin or other device when used for traction or external fixation (except for rigid external fixators) in the treatment of a fracture or other orthopaedic procedure is to be included in the procedural fee (unless otherwise stated in the Schedule) unless a general anaesthetic is required, in which case a fee may be claimed. Removal of devices used for internal fixation more than 30 days after insertion may be claimed for in addition to the procedural benefit.

C. The benefit for total joint replacement also includes denervation of the joint, all tenotomies and division and repair of muscle.

D. The benefit for obtaining a bone graft is not to be claimed in cases of pseudoarthrosis repair, fusions or for listings in which bone grafting is included.

E. For the supervision of limb fitting and 6 months post-operative care following amputation, claim visit fees. Amputation with immediate fitting to include supervision of final limb fitting, add 40% (E586).

Note:
Reconstruction, Arthroplasty: If other procedures are claimed, same joint, same time, e.g. debridement, synovectomy, tendon release etc., the Medical Consultant will assess the surgeon's claim.

FRACTURES AND DISLOCATIONS

1. For fractures or dislocations requiring open or closed reduction or no reduction, the major pre-operative visit, i.e. consultation or appropriate assessment, may be claimed in addition to the listed benefits.

2. **OPEN REDUCTION** shall mean the treatment of a fracture and/or dislocation by either closed intramedullary fixation or by an operative procedure to expose the fracture. The benefits include fixation by internal or external devices.

3. **CLOSED REDUCTION** shall mean the reduction of a fracture or dislocation by non-operative methods (including traction).

4. **NO REDUCTION** shall mean the treatment of a fracture or dislocation by any other method and includes the use of the initial external support other than a simple splint. No reduction, rigid immobilization, means that the device used to achieve a rigid immobilization is custom-molded and is applied by the physician. In cases involving no reduction, application of a simple splint, such as a metal splint, is not billable as rigid immobilization (visit fees only apply).

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

PREAMBLE

5. The service includes all related follow-up treatment by the physician for 2 weeks from the date of treatment of the fracture or dislocation except:

   a. for the first and second post-treatment visits to a hospital in-patient;

   b. for the subsequent visit by the MRP - day of discharge (C124);

   c. for the first post-treatment visit when the patient is no longer a hospital in-patient;

   d. if additional reductions are necessary;

   e. if the patient is transferred to another surgeon;

      or

   f. if the patient is a paraplegic.

   [Commentary:
   The first and second post-treatment visits in hospital for 2 weeks from the date of treatment of the fracture or dislocation are payable at the specialty specific subsequent visit fee.]

6. In multiple fractures or dislocations, the benefit for the major fracture or dislocation shall be 100% and the benefit for the other fractures or dislocations 85%. When no procedural benefit is applicable, but that fracture or dislocation necessitates hospitalization or concurrent care over that demanded by the major injury, a visit benefit may be claimed in addition to other procedural benefits.

7. For repeat reductions (closed or open) for the same fracture or dislocation, the full benefit should be claimed for the final reduction and after care; previous reductions by the same surgeon should be claimed at 85%.

FRACTURES AND DISLOCATIONS

8. Emergency splinting of fractures in the emergency department should be on the basis of appropriate visit benefit, plus application of cast if appropriate.

9. Transferred cases:

   a. When patients are transferred to a chronic or convalescent facility, additional visit benefits on a chronic care basis shall be allowed to other than the operating surgeon (and also to the surgeon after 2 weeks).

   b. When patients are transferred to another physician for after care of fractures and dislocations treated by closed or no reduction, the physician rendering the initial care should claim 75% of the listed fee and the surgeon rendering subsequent care should claim visit fees except where otherwise specified. In cases involving open reduction, the percentage should be 80% for the surgeon providing the initial care.

   c. In cases where the original physician's attempts to reduce a fracture or dislocation under general anaesthesia is unsuccessful, and the patient is referred to another physician for definitive care, the original physician should claim 75% of the listed fee.

10. Pseudoarthrosis may be allowed as the appropriate benefit after the fracture is 4 months old.

11. For fractures and dislocations not requiring reduction, visit fees apply unless a specific fee is listed. If the listed fee is less than the consultation, the consultation should be claimed under the fracture/dislocation fee code number.

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

GENERAL FEES

		Asst	Surg	Anae
	BONE/FASCIAL/DERMIS/GRAFTS			
	Autogenous			
# E551	- separate incision ..... add		86.30	
# E552	- same incision ..... add		58.45	
# Z279	- different surgeon		193.00	
	Homogenous			
# E553	- bank ..... add		25.15	
	Allograft			
	- donor ..... 85% of excision fee			
# R200	- cadaver - per long bone, each		144.80	
	FIXATION			
# E547	- methyl methacrylate (not arthroplasty) ..... add		59.40	
# E555	- rigid external fixation (excluding casts) for closed reduction, to closed reduction fee ..... add 50%			
# E544	- cast bracing with closed reduction, to closed reduction fee ..... add 40%			
# E569	- percutaneous pinning, to closed reduction fee ..... add 50%			
# E590	- rigid external fixation - pseudoarthrosis ..... add		76.10	
	Removal of internal fixation device			
# R267	- general anaesthetic	5	158.65	5
# R268	- local anaesthetic	5	54.85	5
# R598	Removal of extensive external fixation device under general anaesthetic		48.25	5
	Adjustment of circumferential external fixation			
# Z280	- without general anaesthetic		72.35	
# Z281	- with general anaesthetic		145.70	5
# Z210	Insertion traction pin - excludes fractures and dislocations		33.35	
	WOUND CARE			
E550	- insertion of closed irrigation system during a surgical procedure for post-operative management ..... add		63.15	
# E556	- extensive debridement of compound fractures or dislocations, to reduction fee ..... add 50%			2
# Z783	Secondary closure		97.35	5

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

GENERAL FEES

		Asst	Surg	Anae
# R517	Excision of foreign body		107.70	5
# Z250	Chronic Electrical Stimulation (not to include T.E.N.S.) external or internal		193.00	

CASTS

Application of plaster casts or corrective splints are not to be claimed if applied at the time of surgery (except for the application of a cast brace) or applied during the first 2 weeks for a fracture or dislocation when a procedural fee is applicable. The subsequent application of plaster casts may be claimed according to the following schedule.

Direct supervision requires the physical presence of the physician in the office in which the cast is applied at the time the cast is applied unless all conditions listed on page GP42 of the General Preamble (Delegated Procedures) are met.

Z201	Finger		10.25	
E584	- application of plaster cast outside hospital ..... add		11.15	
Z202	Hand		14.90	5
E584	- application of plaster cast outside hospital ..... add		11.15	
Z203	Arm, forearm or wrist		24.10	5
E584	- application of plaster cast outside hospital ..... add		11.15	
Z199	Foot		14.90	5
E584	- application of plaster cast outside hospital ..... add		11.15	
# Z213	Below knee, knee splints (Stove pipe, etc.)		24.10	5
# Z211	Whole leg (mid thigh to toes)		28.80	5
Z198	Toes		10.25	5
E584	- application of plaster cast outside hospital ..... add		11.15	
# Z205	Head and torso	5	97.35	5
# Z208	Shoulder spica	5	97.35	5
# Z206	Body cast	5	57.50	5
	Hip spica			
# Z207	- unilateral	5	97.35	5
# Z209	- bilateral	5	121.60	5
Z216	Wedging of casts in other than fracture treatment		10.25	
Z200	Application of Unna's paste		14.90	
Z873	Application of cast brace (must include hinge)		67.75	
Z204	Removal of plaster (not associated with fractures or dislocations within 2 weeks of initial treatment)		10.25	

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

HAND AND WRIST

		Asst	Surg	Anae
	AMPUTATION			
# R606	Phalanx		161.45	5
# R608	Metacarpal or metaphalangeal joint		190.20	5
# E583	- each additional ... add		94.60	
# R610	Trans. metacarpal 2nd or 5th ray		279.35	5
# R611	Hand - all metacarpals	5	289.50	5
# R612	Wrist	5	289.50	5
# R629	Revision of amputated finger tip	5	241.55	5
	ARTHRODESIS			
# R465	Finger-thumb	5	256.15	5
# R466	Wrist	5	389.75	5
	ARTHROPLASTY			
# E564	- revision of arthroplasty ... add 35%			
	Wrist			
# R437	- interposition	5	374.00	5
# R485	- total	6	426.90	6
# R479	- removal only	5	193.00	6
	Hand - interposition			
# R435	- single	5	254.35	5
# R436	- multiple	5	459.40	6
# R489	Single joint - total	5	290.55	5
# R209	Basal thumb - first carpometacarpal joint	5	363.05	5
# R449	Multiple joints - total maximum (arthrodesis and/or arthroplasties)	5	774.90	6
# R500	Removal only	5	144.80	5
# R236	Carpal replacement	5	322.05	5

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

HAND AND WRIST

		Asst	Surg	Anae
	ARTHROSCOPY			
# E595	- arthroscopy in association with surgery - same surgeon ... add		63.15	
	Note: A maximum of 2 R codes may be billed in conjunction with E595 at any one sitting.			
# Z218	Diagnostic arthroscopy (sole procedure)	5	97.35	5
# R211	Synovial biopsy	5	43.60	
# R212	Removal of loose body, screw	5	192.00	5
# R213	Drilling of defect (includes removal of loose body)	5	251.55	5
	Debridement			
# R221	- local	5	251.55	5
# R224	- total	5	326.55	5
	Synovectomy			
# R230	- partial	5	196.60	5
# R232	- total	5	481.70	5
# R233	Pinning of osteochondral fragment	5	251.55	5
	ARTHROTOMY			
# R409	Finger		168.00	5
# R410	Wrist	5	212.50	5
	ASPIRATION/INJECTION			
	See Diagnostic and Therapeutic Procedures - Injections and Infusions.			
	BIOPSY			
	Bone			
# Z230	- punch, x-ray control		72.35	5
# Z214	- open biopsy or taking of bone graft by other than operating surgeon	5	144.80	5
	Joint			
# E563	- via arthroscope ... add		11.10	
Z221	- needle		49.20	
# R409	- open finger		168.00	5
# R410	- open wrist	5	212.50	5
	Soft tissue			
# Z228	- open		97.35	5
Z219	Muscle needle biopsy, soft tissue, per site		25.15	

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

HAND AND WRIST

		Asst	Surg	Anae
	DECOMPRESSION - DENERVATION			
# N290	Decompression median nerve at wrist (carpal tunnel syndrome)	5	156.50	5
# N285	Exploration and/or decompression and/or transposition and/or neurolysis of major nerve (excluding carpal tunnel nerve)	5	256.15	5
	INCISION AND DRAINAGE			
# R409	Finger joint		168.00	5
# R410	Wrist joint	5	212.50	5
	Phalanx/metacarpal/carpus			
# R219	- incision and drainage	5	182.90	5
# R218	- sequestrectomy	5	144.80	5
# R217	- saucerization and bone graft	5	242.25	5
# R534	Tendon sheath	5	191.85	5
	EXAMINATION/MANIPULATION			
Z222	Manipulation - under general anaesthetic (see Surgical Preamble SP5)		24.10	5

Note:
Without general anaesthetic, see Diagnostic and Therapeutic Procedures - Physical Medicine.

EXCISION

Bone

# R316	Proximal row carpectomy	5	338.75	5
# R285	Carpal - bone (one)	5	214.45	5
# R317	Dorsal exostosis (triquetrum)	5	189.75	5
# R286	Radial styloid	5	234.75	5
# R283	Phalanx/metacarpal	5	193.00	5
# R272	Bone tumour (see General Preamble GP12)	I.C	I.C	I.C

Joint

Synovectomy/capsulectomy/debridement

# R425	- finger joint	5	226.40	5
# R414	- two or more joints	5	339.65	5
# R407	Synovectomy of extensor or flexor tendons		224.45	5
# R418	Synovectomy/debridement - wrist	5	342.55	5
# R492	Radio-ulnar meniscectomy	5	231.10	5

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

HAND AND WRIST

		Asst	Surg	Anae
	EXCISION			
	Muscle and Tendon			
	Muscle			
# R522	- simple	5	193.00	5
# R523	- complex	5	484.35	6
	Tendon sheath			
# R550	- single	5	241.60	5
# E572	- each additional add		200.20	
	Fascia for Dupuytrens			
# R551	- simple or complex with or without flaps or grafts	5	322.15	5
	Ganglion			
# R549	Simple or complex	5	177.80	5
	RECONSTRUCTION			
	Bone - Pseudoarthrosis			
# R321	Phalanx, metacarpal	5	260.75	5
# R322	Scaphoid - must include bone graft and fixation	5	363.80	5

Note:
F019, Z279, and E551 rendered in conjunction with R322 are insured services payable at nil.

	Bone - Deformity			
	Osteotomy - phalanx			
# R257	- terminal		162.65	5
# R258	- middle proximal or metacarpal	5	193.20	5
# E591	- each additional add		158.65	
	Ligaments			
# R597	Simple/single repair - wrist	5	301.60	5
# R548	Extensive/multiple repair - wrist	5	511.45	5
# R601	Metacarpal phalangeal repair	5	316.75	5

Note:
Reconstruction - Nerve - see page X7.

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

HAND AND WRIST

RECONSTRUCTION

		Asst	Surg	Anae
	Tendon			
	Tenoplasty			
# R557	- one	5	223.65	5
# E050	- each additional ... add		77.05	
	Tendon graft			
# R559	- one	5	306.30	5
# E052	- each additional ... add		259.85	
# R586	Reconstruction of flexor tendon pulley, per finger		97.35	5
	Silicone rod insertion			
# R554	- one	5	294.20	5
# E051	- each additional ... add		245.90	
	Transplant/transfer			
# R563	- single	5	284.95	5
# E054	- each additional ... add		236.10	
	Tendon repair - extensor			
# R578	- single	5	164.10	5
# E580	- each additional* ... add		70.95	
	Flexor			
# R585	- single	5	307.60	5
# E581	- each additional* ... add		128.95	
	Mallet finger			
UVC	- closed		visit.fee	
# R574	- K-wire		133.95	5
# R573	- open	5	147.20	5
	Boutonniere			
UVC	- closed		visit.fee	
# R577	- open	5	147.30	5
# R582	- late	5	246.65	5

Note:
*If additional tendon repair(s) requires a separate incision, bill according to Surgical Preamble SP3.

Extremities

# R602	Pollicization	6	596.35	6
# R603	Digital reimplantation involving microvascular and neuro anastomosis	8	1586.20	8
# R604	Revision of R602, R603 (see General Preamble GP12)	I.C	I.C	I.C
# R605	Reconstruction and plastic repair of traumatically amputated extremities (see General Preamble GP12)	I.C	I.C	I.C

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

HAND AND WRIST

		Asst	Surg	Anae
	RELEASE			
	Tendon			
	Tenolysis - flexor and/or extensor tendon of			
# R575	- one digit	5	194.05	5
# E537	- each additional digit ... add		165.20	
# R541	Flexor tenolysis with pulley preservation	5	283.45	5
	Tenotomy or fasciotomy (closed)			
	Finger			
# Z247	- one		49.20	5
# Z248	- two		72.35	5
# Z249	- three or more		99.15	5
# Z231	- palmar or plantar		73.70	5
	Tendon release (open)			
# R536	- finger/palm		106.90	5
# R537	- wrist	5	137.10	5
# E571	- more than one ... add		117.00	
	REDUCTION			
	Fractures			
	Phalanx			
F004	- no reduction, rigid immobilization		49.20	
F005	- closed reduction		99.25	5
E584	- application of plaster cast outside hospital ... add		11.15	
E558	- each additional ... add		22.25	
# F007	- open reduction	5	248.70	5
	Metacarpal			
F008	- no reduction, one or more, rigid immobilization		49.20	
F009	- closed reduction		99.25	5
E584	- application of plaster cast outside hospital ... add		11.15	
E504	- each additional ... add		22.20	
# F011	- open reduction	5	218.85	5
E559	- each additional (open) ... add		142.90	
	Intra-articular			
F006	- closed reduction		119.75	
E584	- application of plaster cast outside hospital ... add		11.15	
E503	- each additional ... add		26.85	
# F010	- open reduction	5	279.85	5

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

HAND AND WRIST

			Asst	Surg	Anae
	REDUCTION				
	Fractures				
	Bennett's				
F012	- no reduction, rigid immobilization			49.20	
E584	- application of plaster cast outside hospital	add		11.15	
# F013	- closed reduction		5	119.80	5
# F015	- open reduction		5	279.85	5
	Carpus				
F102	- no reduction, rigid immobilization			49.20	
E584	- application of plaster cast outside hospital	add		11.15	
# F016	- closed reduction, one or more			115.10	5
# F017	- open reduction, one or more		5	288.45	5
	Scaphoid				
F018	- no reduction, rigid immobilization			49.20	
E584	- application of plaster cast outside hospital	add		11.15	
# F019	- open reduction		5	314.95	5
# F020	- excision		5	193.00	5
	Dislocations				
	Finger				
D001	- closed reduction			57.50	5
E584	- application of plaster cast outside hospital	add		11.15	
E576	- each additional	add		10.25	
# D003	- open reduction		5	196.50	5
	Metacarpal/phalangeal				
D004	- closed reduction			57.50	5
E584	- application of plaster cast outside hospital	add		11.15	
E577	- each additional	add		10.25	
# D006	- open reduction		5	181.85	5
	Carpal				
D007	- closed reduction			128.05	5
E584	- application of plaster cast outside hospital	add		11.15	
# D008	- open reduction		5	241.30	5

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

ELBOW AND FOREARM

		Asst	Surg	Anae
	AMPUTATION			
# R613	Through radius and ulna	5	306.30	5
# R614	Elbow disarticulation	5	289.50	5
	ARTHRODESIS			
# R466	Elbow	5	389.75	5
	ARTHROPLASTY			
# E564	- revision of elbow arthroplasty	add 35%		
# R281	Ulna replacement (lower end)	5	296.90	5
# R288	Implant radial head	5	251.55	5
# R499	Removal of total replacement	5	402.75	7
# R486	Complete arthroplasty replacement	6	619.90	8
# R510	Interposition arthroplasty	6	435.20	7
	ARTHROSCOPY			
# E595	- arthroscopy in association with surgery - same surgeon	add	63.15	
	Note: A maximum of 2 R codes may be billed in conjunction with E595 at any one sitting.			
# Z218	Diagnostic arthroscopy (sole procedure)	5	97.35	5
# R211	Synovial biopsy	5	43.60	5
# R212	Removal of loose body, screw	5	192.00	5
# R213	Drilling of defect (includes removal of loose body)	5	251.55	5
	Debridement			
# R221	- local	5	251.55	5
# R224	- total	5	326.55	5
	Synovectomy			
# R230	- partial	5	196.60	5
# R232	- total	5	481.70	5
# R233	Pinning of osteochondral fragment	5	251.55	5
	ARTHROTOMY			
# R445	Elbow, loose body, etc.	5	199.55	5

ASPIRATION/INJECTION

See Diagnostic and Therapeutic Procedures - Injections and Infusions.

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

ELBOW AND FOREARM

			Asst	Surg	Anae
	BIOPSY				
	Bone				
Z225		- needle		72.35	5
# Z214		- open		144.80	5
	Joint				
# R432		- open	5	171.45	5
# E563		- via arthroscope	add	11.10	
# Z228	Muscle/soft tissue			97.35	5
Z219	Muscle needle biopsy, soft tissue, per site			25.15	
	DECOMPRESSION/DENERVATION				
# R495	Fasciotomy for compartment syndrome (not including secondary closure wound)		5	320.20	5
# Z783	Secondary closure			97.35	5
	Catheter				
# Z251		- insertion		49.20	
UVC		- monitoring		visit fee	
# N190	Exploration and/or decompression and/or neurolysis of ulnar nerve (elbow)		5	215.35	5
# N189	Ulnar nerve transposition at elbow - may include exploration, decompression and/or neurolysis		5	279.25	5
# R426	Denervation - elbow		5	258.00	5
	INCISION AND DRAINAGE				
# R228	Acute		5	302.55	5
# Z226	Soft tissue or bursa, incision and drainage			97.35	5
# R445	Elbow		5	199.55	5
# R231	Sequestrectomy		5	355.35	5
# R229	Saucerization and bone grafting		5	452.90	5
	EXAMINATION/MANIPULATION				
Z222	Manipulation - under general anaesthetic (see Surgical Preamble SP5)			24.10	5

Note:
Without general anaesthetic, see Diagnostic and Therapeutic Procedures - Physical Medicine.

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

ELBOW AND FOREARM

		Asst	Surg	Anae
	EXCISION			
	Bone			
# R287	Radial head	5	217.95	5
# R286	Radial styloid	5	234.75	5
# R643	Ulna lower end	5	193.00	5
# R290	Olecranon	5	207.90	5
# R291	Olecranon with fascial repair	5	309.00	5
	Bursae			
# R595	Olecranon	5	101.25	5
	Joint Contents			
# R421	Synovectomy/capsulectomy/debridement, etc.	5	311.85	5
	Muscles			
# R524	Myositis ossificans	5	289.50	5
# R517	Foreign body removal		107.70	5
	Tumours			
	Soft tissues			
# R591	- superficial	5	196.05	5
# R592	- deep	5	484.35	6
	Bone tumours			
# R294	- exostosis	5	165.20	5
# R295	- simple excision	5	289.50	5
# R293	- extensive with replacement	5	677.50	6
	RECONSTRUCTION			
	Bone - Pseudoarthrosis			
# R323	Radius or ulna	5	304.40	5
# R473	Radius and ulna	5	411.20	5
# R950	Radius and ulna - circular external fixation	5	291.40	5
	Bone - Deformity			
	Osteotomy			
# R259	- radius or ulna	5	297.85	5
# R324	- radius and/or ulna with reconstruction congenital abnormality, synostosis etc.	5	398.10	5
# R951	Single level correction - circular external fixation	5	638.40	5
# R952	Double level correction - circular external fixation	5	798.10	5
	Bone transport			
# R953	- circular external fixation (less than or equal to 6 cm)	5	655.15	5
# R954	- circular external fixation (greater than 6 cm)	5	763.80	5

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

ELBOW AND FOREARM

		Asst	Surg	Anae
	RECONSTRUCTION			
	Fascia			
	Repair fascial defects			
# R476	- small	5	144.80	5
# R478	- large with or without synthetic graft or rotation flap	5	290.55	5
	Ligaments			
# R597	Simple/single repair	5	301.60	5
# R548	Extensive/multiple repair	5	511.45	5
	Tendons			
	Suture extensor tendon			
# R578	- single	5	164.10	5
# E580	- each additional add		70.95	
	Suture flexor tendon			
# R585	- single	5	307.60	5
# E581	- each additional add		128.95	
	Tenoplasty			
# R557	- single	5	223.65	5
# E050	- each additional add		77.05	
	Tenolysis			
# R556	- single	5	202.25	5
# E599	- each additional add		87.20	
	Transposition/transplantation/transfer			
# R563	- single	5	284.95	5
# E056	- each additional add		91.90	
# R583	Steindler flexoplasty	5	344.85	5
	RELEASE			
	Muscles and tendons			
# R519	- simple, e.g. tennis elbow	5	136.35	5
# R521	- radical, e.g. muscle slide	5	314.60	5
	REDUCTION			
	Dislocations			
	Elbow joint			
# D009	- closed reduction		84.45	5
# D010	- open reduction - acute	5	252.45	
# R400	- repair chronic, recurrent	5	379.50	5
	Radial head			
# D012	- closed reduction, pulled elbow		39.00	5
# D011	- open reduction - acute	5	193.00	5
# R540	- open reduction - recurrent	5	227.40	6
# R558	- open reduction - late	5	357.20	6

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

ELBOW AND FOREARM

			Asst	Surg	Anae
	REDUCTION				
	Fractures				
	Epicondyle				
# F029	- no reduction			67.75	
# F037	- closed reduction		5	126.25	5
# F038	- open reduction		5	214.45	5
	Transcondylar/condylar				
# F039	- no reduction			67.75	
# F040	- closed reduction		5	298.35	5
# F045	- closed reduction with traction		5	312.70	5
# F041	- open reduction		5	375.80	5
	Olecranon				
# F034	- no reduction, rigid immobilization			126.25	5
# F035	- closed reduction		5	129.00	5
# F036	- open reduction		5	224.55	5
	Radius and ulnar shaft				
# F024	- no reduction, rigid immobilization			67.75	
# F025	- closed reduction		5	148.50	5
# F026	- open reduction		5	368.40	5
	Radius and ulna - Monteggia				
# F014	- no reduction, rigid immobilization			67.75	
# F022	- closed reduction			144.80	5
# F023	- open reduction of ulna plus closed reduction radial head		5	242.25	5
	Radius or ulna				
F031	- no reduction, rigid immobilization			67.75	
E584	- application of plaster cast outside hospital	add		11.15	
# F032	- closed reduction		5	117.85	5
# F033	- open reduction		5	228.35	5
	Radius - distal, e.g. Colles', Smith's, or Barton's fracture				
F027	- no reduction, rigid immobilization			67.75	
E584	- application of plaster cast outside hospital	add		11.15	
# F028	- closed reduction, under local or regional anaesthetic			109.45	
# F046	- closed reduction, under general anaesthetic		5	149.35	5
# F030	- open reduction		5	281.15	5
	Osteochondral				
# F021	- open reduction		5	327.00	5

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

SHOULDER, ARM AND CHEST

		Asst	Surg	Anae
	AMPUTATION			
# R617	Forequarter	10	490.95	15
# R616	Shoulder disarticulation	9	373.10	9
# R615	High humerus	5	369.35	5
	ARTHRODESIS			
# R467	Shoulder	5	468.65	6
	ARTHROPLASTY			
# E564	- revision of prosthesis	add 35%		
# R438	Humeral prosthesis	5	449.20	6
# R487	Total prosthesis	6	695.10	10
# R240	Revision total arthroplasty shoulder	6	942.95	10
# R498	Removal prosthesis/no replacement	5	397.20	8
	ARTHROSCOPY			
# E595	- arthroscopy in association with surgery - same surgeon	add	63.15	
# Z218	Diagnostic arthroscopy (sole procedure)	5	97.35	5
# R211	Synovial biopsy	5	43.60	5
# R212	Removal of loose body, screw	5	192.00	5
# R213	Drilling of defect (includes removal of loose body)	5	251.55	5
	Debridement			
# R221	- local	5	251.55	5
# R224	- total	5	326.55	5
	Synovectomy			
# R230	- partial	5	196.60	5
# R232	- total	5	481.70	5
# R233	Pinning of osteochondral fragment	5	251.55	5

Note:
A maximum of 2 R codes may be billed in conjunction with E595 at any one sitting.

ARTHROTOMY

# R411	Shoulder	5	223.65	5

ASPIRATION/INJECTION

See Diagnostic and Therapeutic Procedures - Injections and Infusions.

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

SHOULDER, ARM AND CHEST

			Asst	Surg	Anae
	BIOPSY				
	Bone				
Z220	- needle/punch, x-ray control			72.35	5
# Z214	- open		5	144.80	5
	Joint				
# R411	- open		5	223.65	5
# E563	- via arthroscope	add		11.10	
# Z228	Soft tissue - open			97.35	5
Z219	Muscle needle biopsy, soft tissue, per site			25.15	
	INCISION AND DRAINAGE				
# R222	Humerus/clavicle/scapula		5	262.60	5
# Z226	Bursae/soft tissue			97.35	5
# R411	Joint		5	223.65	5
# R225	Sequestrectomy		5	290.55	
# R223	Saucerization with bone graft		5	387.90	
	EXAMINATION AND MANIPULATION				
Z223	Manipulation under general anaesthetic (see Surgical Preamble SP5)			49.20	5
	Note: Without general anaesthetic, see Diagnostic and Therapeutic Procedures - Physical Medicine				
	EXCISION				
	Clavicle or Acromion				
# R298	Simple (includes ligament)		5	211.60	5
	Note: When R298 is rendered in association with R416, R298 is payable at 100% and R416 is payable at 85%.				
# R641	Major tumour		5	290.55	6
# R214	Malignant tumour with reconstruction		5	484.35	6
	Humerus				
# R292	Head		5	299.75	5
# R294	Exostosis		5	165.20	5
# R295	Benign tumour		5	289.50	5
# R297	Malignant tumour with reconstruction		5	681.10	6

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

SHOULDER, ARM AND CHEST

		Asst	Surg	Anae
	EXCISION			
	Joint			
# R422	Synovectomy and debridement	5	425.10	5
# R512	Excision of subacromial bursa (not to be claimed with R416)	5	211.60	5
	Muscle/fascia			
# R522	- simple	5	193.00	
# R523	- complex	5	484.35	6
# R416	Rotator cuff exploration - includes acromioplasty, excision of coraco-acromial ligament and subacromial bursa but excludes simple excision of clavicle	5	206.90	5

Note:
When R416 is rendered in association with R298, R416 is payable at 85% and R298 is payable at 100%.

	RECONSTRUCTION			
	Pseudoarthrosis			
# R329	Clavicle	5	269.10	5
# R325	Humerus	5	346.15	5
# R956	Humerus - circular external fixation	5	291.40	5
	Deformity			
	Osteotomy			
# R260	- humerus	5	292.35	5
# R298	- clavicle	5	211.60	5
# R235	- glenoid	5	279.35	5
# R957	Single level correction - circular external fixation	5	510.35	5
# R958	Double level correction - circular external fixation	5	638.40	5
	Bone transport			
# R959	- circular external fixation (less than or equal to 6 cm)	5	655.15	5
# R960	- circular external fixation (greater than 6 cm)	5	763.80	5
	Humeral lengthening			
# R961	- circular external fixation (less than or equal to 6 cm)	5	438.00	5
# R962	- circular external fixation (greater than 6 cm)	5	655.15	5

Note:
Reconstruction - Nerves - see Operations on the Nervous System.

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

SHOULDER, ARM AND CHEST

		Asst	Surg	Anae
	RECONSTRUCTION			
	Muscles/Soft Tissues			
# R527	Muscle transplant - pectoralis major	6	434.25	6
# R353	Scapulopexy congenital elevation	6	385.15	6
# R568	Trapezius/sternomastoid transplant	5	338.65	5
	Tendon repair			
# R589	- biceps	5	227.40	5
	Rotator cuff repair			
# R593	- simple, end-to-end or side-to-side (includes acromioplasty, excision of coraco-acromial ligament)	5	316.40	5
# R594	- complex (includes implantation into bone, and as required, acromioplasty, excision of coraco-acromial ligament, excision of distal clavicle)	5	466.85	5
# E057	- revision/repair following previous rotator cuff surgery, to R594	add 30%		
	RELEASE			
# R521	Muscle/tendon	5	314.60	5
# R526	Sternomastoid	5	296.05	5
	REDUCTION			
	Fractures			
	Tuberosity			
# F047	- no reduction		67.80	
# F048	- closed reduction	5	117.85	5
# F049	- open reduction (without cuff tear)	5	290.55	5
	Neck without dislocation of head			
# F053	- no reduction		67.80	
# F054	- closed reduction		133.60	5
# F055	- open reduction	5	327.55	6
	Neck with dislocation of head			
# F050	- no reduction		67.80	
# F051	- closed reduction	5	183.80	5
# F052	- open reduction	5	385.15	6
	Shaft			
# F042	- no reduction		67.80	
# F043	- closed reduction	5	147.60	5
# F044	- open reduction	5	323.05	5

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

SHOULDER, ARM AND CHEST

		Asst	Surg	Anae
	REDUCTION			
	Fractures			
	Clavicle			
UVC	- no reduction		visit fee	
# F110	- closed reduction with anaesthetic	5	62.20	5
# F118	- open reduction	5	231.10	5
	Scapula			
# F119	- no reduction		67.80	
# F121	- open reduction	5	242.25	5
	Sternum			
# F123	- closed reduction		115.95	
# F124	- open reduction - pleura open (see General Preamble GP12)	9	I.C	13
# F125	- pleura closed (see General Preamble GP12)	5	I.C	5
	Ribs			
UVC	- no reduction		visit fee	
# F131	- pleura closed (see General Preamble GP12)	5	I.C	5
	Dislocations			
	Acromio-clavicular/sterno-clavicular			
# D014	- no reduction		67.80	
# D025	- closed with anaesthetic	5	134.55	5
# D023	- open reduction	5	231.10	5
# R596	- late	5	286.70	5
	Glenohumeral joint			
# D015	- closed reduction without anaesthetic		49.20	
# D016	- closed reduction with anaesthetic		111.40	5
# D017	- open reduction, early	5	323.85	6
# R472	- open reduction, late	5	580.90	7
# R401	- open reduction, recurrent	5	379.50	5
# E058	- revision/repair following previous glenohumeral joint surgery, to R401	add 30%		

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

SKULL AND MANDIBLE

		Asst	Surg	Anae
	ARTHROPLASTY			
# R433	Temporomandibular joint - unilateral	5	349.30	5
	BIOPSY			
	Bone			
# Z869	- punch, simple		39.10	5
# Z870	- punch, x-ray control		97.35	5
# Z242	- open	5	193.00	5
	INCISION AND DRAINAGE			
# Z234	Mandibular sequestrectomy	7	281.25	7
	EXCISION			
# R272	Bone - tumour (see General Preamble GP12)	I.C	I.C	I.C
# R278	Maxilla, with exenteration of orbit and skin graft	5	532.95	7
# R279	Maxilla advancement	5	440.15	8
# R280	Mandible	5	353.10	7
# R284	Mandibular condyle	5	276.55	5
# R428	Temporomandibular meniscectomy	5	249.75	5
	RECONSTRUCTION			
	Facial paralysis			
# R531	- static slings	5	307.15	5
# R532	- dynamic slings	5	399.00	6
# R533	Composite repair for facial paralysis, plication of paralyzed muscles, and resection for paralysis of over active muscles	5	511.90	7
# E597	- with meloplasty add		87.05	

Note:
Claims for R533 will be assessed by the Medical Consultant

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

SKULL AND MANDIBLE

			Asst	Surg	Anae
	ORTHOGNATHIC SURGERY				
	Anterior dento-alveolar osteotomy, maxilla or mandible				
# R382	- one segment		6	803.80	10
# R383	- two segments		6	932.10	10
	Posterior dento-alveolar osteotomy, maxilla				
# R349	- one side		6	803.80	10
# R351	- both sides, single segment		6	932.10	10
# R385	- both sides, separate segments		6	1187.50	10
	Posterior dento-alveolar osteotomy, mandible				
# R462	- one side		6	803.80	10
# R463	- both sides		6	1187.50	10
	Total U dento-alveolar osteotomy				
# R502	- mandible		6	1228.70	10
# R507	- maxilla		6	1315.70	10
# R511	Mandibular or maxillary visor osteotomy for alveolar hypoplasia		6	1146.40	10
	Genioplasty				
# R386	- one segment		6	256.40	10
# R387	- two segments, or for laterognathia		6	383.65	10
# R388	- three segments		6	511.90	10
	Mandibular osteotomies for prognathism				
# R480	- subcondylar		5	420.10	6
# R384	- vertical ramus		6	932.10	10
# R518	- sagittal split		6	932.10	10
	Mandibular osteotomies for retrognathia, any technique				
# R520	- advancement - up to 10 mm		6	932.10	10
# R529	- advancement - 10 to 20 mm, inclusive		6	1058.40	10
# R535	- advancement - greater than 20 mm		6	1356.90	10
# E588	- for apertognathia or laterognathia	add		256.40	

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

SKULL AND MANDIBLE

			Asst	Surg	Anae
	ORTHOGNATHIC SURGERY				
	LeFort I advancement				
# R379	- in one segment		10	803.80	20
# E961	- in two segments	add		296.60	
# E962	- in three segments	add		594.20	
	LeFort I intrusion				
# R538	- in one segment		10	1059.35	20
# E963	- in two segments	add		296.60	
# E964	- in three segment	add		594.20	
	LeFort I extrusion				
# R567	- in one segment*		10	1315.70	20
# E965	- in two segments	add		296.60	
# E966	- in three segments	add		594.20	
	LeFort I cleft palate				
# R580	- in one segment*		10	1525.30	20
# E967	- in two segments	add		256.40	
# E968	- in three segments	add		511.90	
# E969	- with SMR	add		204.80	
# E970	- with pharyngoplasty	add		307.15	
# E971	- with closure alveolar fistula with or without bone graft	add		383.65	
# E972	- with closure hard palate fistula with or without bone graft	add		511.90	
# R588	Naso-maxillary osteotomy without LeFort I*		6	803.80	10
# R389	LeFort II maxillary osteotomy and advancement*		10	1443.95	20
# R395	Construction glenoid fossa and zygomatic arch* (Obwegeser technique)		10	1402.75	20
# R396	Construction absent condyle and ascending ramus*		6	803.80	10
# R609	Combined LeFort I and LeFort III osteotomy in hemifacial microsomia		10	1586.20	20
# R145	Mandibular condylotomy		5	204.80	5
# R618	Coronoidotomy		5	204.80	5
# R644	Coronoidectomy		5	307.15	5

Note:
* Includes harvesting and grafting of bone or cartilage grafts

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

SKULL AND MANDIBLE

		Asst	Surg	Anae
	ORTHOGNATHIC SURGERY			
	Reconstruction mandible with bone grafts* and/or plate or prosthesis.			
	Unilateral			
# R334	- partial	5	409.55	10
# R335	- complete	5	819.15	10
	Bilateral			
# R645	- partial	5	819.15	10
# R646	- complete	5	1023.95	10
	Oral vestibuloplasty			
# R647	- with secondary epithelization	5	204.80	5
# R648	- with skin graft	5	307.15	5
	Temporomandibular ankylosis			
# R649	- excision bone or fibrous block	5	461.30	6
# R650	- with insertion of prosthetic device or muscle flap	5	511.90	8
# R651	- with construction of condyle and ascending ramus*	5	666.00	10
	Onlay bone grafts to face when not part of standard osteotomy for reconstruction*			
	Mandible			
# Z253	- unilateral		358.90	
# Z254	- bilateral		461.30	
	Maxilla			
# Z255	- unilateral		358.90	
# Z256	- bilateral		461.30	
	Zygoma			
# Z257	- unilateral		307.15	
# Z258	- bilateral		409.55	
	Temporal			
# Z259	- unilateral		409.55	
# Z260	- bilateral		511.90	
	Frontal			
# Z261	- unilateral		409.55	
# Z262	- bilateral		511.90	
	Application of dental arch bars, or splint, for facial osteotomy			
# Z239	- one arch bar	5	133.00	5
# Z240	- two arch bars	5	204.80	5
# R354	Interdental wiring for temporomandibular joint disorder	5	154.00	5
# R652	Removal intermaxillary fixation devices under general anaesthesia - as sole procedure		102.35	5

Note:
* Includes harvesting and grafting of bone or cartilage grafts.

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

SKULL AND MANDIBLE

			Asst	Surg	Anae
	ORBITO-CRANIAL SURGERY				
	Bilateral periorbital correction Treacher-Collins Syndrome				
# R390	- with or without bone grafts* (extra-cranial)		10	1699.45	20
# R653	- with skull and muscle transpositions* (includes skull reconstruction) (intracranial)		10	2196.35	25
	Pericranial flap to orbit or face				
# R654	- unilateral			307.15	5
E973	- when in conjunction with coronal approach for main operation	add		178.90	
# R655	- bilateral			409.55	5
# E974	- when in conjunction with coronal approach for main operation	add		297.55	
# R378	LeFort III total maxillary advancement*		12	2037.35	25
# R656	LeFort III and subcranial hypertelorism correction*		12	2590.35	25
# R657	LeFort III and LeFort I maxillary advancement*		12	2334.85	25
# R658	LeFort II, subcranial hypertelorism correction Le Fort I maxillary advancement*		12	2928.10	25
	Upper LeFort III advancement without occlusal change*				
# R659	- unilateral		6	932.10	10
# R675	- bilateral		12	1443.95	25
	Forehead advancement (bone grafts not included)				
# R676	- unilateral		12	1187.50	25
# R393	- bilateral		12	1443.95	25
# R394	Cranial vault reshaping* - anterior or posterior half		10	1525.30	20
# R677	Total cranial vault reshaping*		12	2078.35	25
	Medial transnasal canthopexy				
# R398	- unilateral		5	414.30	6
# E557	- when done in conjunction with another procedure	add		154.00	

Note:
* Includes harvesting and grafting of bone or cartilage grafts

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

SKULL AND MANDIBLE

			Asst	Surg	Anae
	ORBITO-CRANIAL SURGERY				
	Lateral canthoplasty				
# R399	- unilateral		5	204.80	6
# E930	- when done in conjunction with another procedure	add		102.35	
	Hypertelorism correction				
# R376	- intracranial approach*		12	2334.85	25
# R377	- subcranial U osteotomies*		12	1950.15	25
# R678	- medial orbital wall osteotomies*		10	1228.70	20
# R679	- medial and lateral orbital wall osteotomies*		10	1612.30	20
	Orbital dystopia*				
# R391	- intracranial approach		12	1950.15	25
# R392	- extracranial approach		10	1485.10	20
	Orbital cranial osteotomy*				
# R380	- intracranial approach		12	1495.50	25
# R381	- extracranial approach		10	1121.50	20
	Late correction traumatic enophthalmos				
	Tessier Technique - total periorbital stripping and bone grafts				
# R680	- intracranial		12	1997.05	25
# R681	- extracranial		10	1443.95	20
	Harvesting of bone graft when not included				
# Z263	Iliac bone graft			102.35	
	Rib graft				
# Z264	- one rib			154.00	
# E975	- each subsequent rib	add		76.50	
	Costochondral or chondral graft				
# Z265	- one rib			230.65	
# E976	- each subsequent rib	add		154.00	
# Z266	- split cranial graft			204.80	

Note:
* Includes harvesting and grafting of bone or cartilage grafts.

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

SKULL AND MANDIBLE

Asst | Surg | Anae

SURGERY FOR CORRECTION OF DOWN'S SYNDROME FACIAL STIGMATA

Augmentation of zygoma (bilateral)

# Z267	- with prosthetic implant	184.60
# Z268	- with autogenous bone or cartilage*	230.65

Augmentation of chin

# Z269	- with prosthetic implant	154.00
# Z270	- with autogenous bone or cartilage*	189.45
# Z271	Horizontal resection, red lower lip	184.60

Note:
* Includes harvesting and grafting of bone or cartilage grafts.

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

SKULL AND MANDIBLE

		Asst	Surg	Anae
	REDUCTION			
	Fractures			
	Orbit - open reduction rim/wall fracture			
# E173	Zygomatic fracture dislocation	5	276.55	6
# E933	- with miniplate(s)**, per major fracture line ... add		69.05	
# E934	- with primary bone graft (separate site) ... add		204.80	
	Orbit			
# E174	- blowout fracture of floor	5	322.45	6
# E934	- with primary bone graft (separate site) ... add		204.80	
	Nasal bones - to include manipulation of nasal septum			
# F136	- closed reduction		102.35	5
# F137	- open reduction***		256.40	5
# E825	- with miniplate(s)**, per major fracture line ... add		63.95	
	Orbit with maxilla			
# F150	- closed reduction and dental wiring		256.40	5
# F142	- with wiring and local fixation	5	394.25	6
# E830	- with miniplate(s)**, per major fracture line ... add		98.55	
# E932	- unilateral ... add		205.00	
# E935	- bilateral ... add		307.70	

Note:
E932, E934, and E935 are not to be billed with Z263, Z264, Z265, Z266, E975, or E976.

	Midface fractures			
	- application of craniofacial suspension wires and external fixation devices (not to be billed in addition to maxillary repair).			
# F143	- middle ¼ facial	5	429.60	8
# E830	- with mini-plate(s)**, per major fracture line ... add		98.55	
# F144	- cranial-facial separation	6	542.60	10
# E830	- with mini-plate(s)**, per major fracture line ... add		98.55	
	Mandible			
# F138	- closed reduction (including wiring of teeth)	5	256.40	5
# F139	- open reduction (may include wiring of teeth) one side	5	342.55	5
# E828	- with miniplate(s)**, per major fracture line ... add		85.70	
# F146	- complicated (see General Preamble GP12)	I.C	I.C	I.C

Note:

1. ** Where mini-plate(s) are used, one mini-plate fee per each major fracture line (e.g. infraorbital, malar-zygomatic, nasal-frontal, LeFort I, LeFort II and III) (per major fracture line per side) should be billed.
2. *** If a full septoplasty is performed, claim in addition the septoplasty codes at 50%. See listings under Nose - Reconstruction.

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

SKULL AND MANDIBLE

		Asst	Surg	Anae
	REDUCTION			
	Dislocations			
	Temporomandibular joint			
# D062	- closed reduction		51.65	5
# D063	- open reduction	5	256.40	5

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

PELVIS AND HIP

			Asst	Surg	Anae
	AMPUTATION				
# R631	Hemipelvectomy - hindquarter		10	796.20	15
# R630	Hip disarticulation		10	449.20	10
	ARTHRODESIS				
# R469	Sacro-iliac joint		5	395.25	5
# R514	Symphysis pubis		5	387.00	6
# R470	Hip		5	703.45	8
	ARTHROPLASTY				
# R439	Unipolar		6	490.95	8
# R440	Total hip replacement - acetabulum and femur		8	696.00	8
# R553	Total hip replacement with take down of fusion		8	972.90	10
	Revision total arthroplasty hip - one or both components				
# R241	- acetabular or femoral		8	1304.80	10
# E589	- bone graft to acetabulum	add		101.25	
# E593	- acetabular reconstruction (extensive, including bone grafts)	add		194.00	
# R481	Reattachment of greater trochanter (late)		6	290.55	8
	Removal only				
# R443	- non-cemented		5	447.30	8
# R488	- cemented		5	557.75	8
# R491	Replacement acetabular liner and/or femoral head		8	353.25	8
	ARTHROSCOPY				
# E595	- preceding surgery - same surgeon	add		63.15	
	Hip joint				
# Z218	- sole procedure			97.35	5

Note:
A maximum of 2 R codes may be billed in conjunction with E595 at any one sitting.

	ARTHROTOMY				
# R547	Sacro-iliac joint		5	290.55	6
# R415	Hip - with removal of loose body		5	301.60	6

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

PELVIS AND HIP

		Asst	Surg	Anae
	ASPIRATION/INJECTION			
	See Diagnostic and Therapeutic Procedures - Injections and Infusions.			
# Z290	Hip - infant or child, under general anaesthesia	5	63.95	5
	BIOPSY			
	Bone			
Z212	- punch needle		72.35	
# Z217	- under general anaesthetic		72.35	5
# Z214	- open		144.80	5
	Joint			
# R415	- open	5	301.60	6
# E563	- via arthroscope	add	11.10	
	Soft tissue			
# Z228	- open		97.35	5
Z219	Muscle needle biopsy, soft tissue, per site		25.15	
	DENERVATION/DECOMPRESSION			
	Exploration, decompression, division, excision, biopsy, neurolysis and/or transposition			
# N188	- minor nerve - including digital, cutaneous or lateral femoral cutaneous nerve	5	153.70	5
# N285	- major nerve - excluding carpal tunnel or ulnar nerve at elbow	5	256.15	5
# N177	Sciatic nerve in buttock	6	430.75	
R427	Denervation of hip	5	387.00	5
	Note: N188 or N285 when performed through the same incision as flexor tendon repairs R585 or E581 is an insured service payable at nil.			
	INCISION AND DRAINAGE			
# R269	Bone	5	290.55	5
# Z226	Bursae/soft tissue		97.35	5
# R415	Joint	5	301.60	6
# R249	Sequestrectomy	5	379.50	5
# R250	Saucerization and bone graft	5	627.30	5
	EXAMINATION/MANIPULATION			
Z252	Manipulation - under general anaesthetic		39.00	5
	Note: Without general anaesthetic, see Diagnostic and Therapeutic Procedures - Physical Medicine.			

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

PELVIS AND HIP

		Asst	Surg	Anae
	EXCISION			
	Bone			
# R639	Simple cyst, etc	5	338.75	5
# R330	Major resection tumour	5	629.65	6
# R216	Radical resection tumour	8	1007.35	8
# F115	Coccyx	5	208.80	5
# R315	Head and neck, femur	5	452.90	6
	Muscle			
# R522	- simple	5	193.00	5
# R523	- complex	5	484.35	6
# R524	- myositis	5	289.50	5
	Joint			
# R423	Synovectomy/debridement	5	470.50	5
	Bursae			
# R590	GT trochanteric/ischial	5	201.40	5
	RECONSTRUCTION			
	Pseudoarthrosis			
# R364	Pelvis	8	580.90	10
# R328	Hip	6	477.90	6
	Osteotomy			
	Pelvis			
# R265	- infant	8	399.00	8
# R273	- other	8	580.90	8
# R263	Hip	5	539.15	7
	Muscle/Tendon			
# R521	Muscle release	5	314.60	5
	Tenotomy			
# Z232	- closed adductors		49.20	5
# Z233	- open adductors		97.35	5
# R545	- iliopsoas	5	266.35	5
	Tendon Transfer			
# R570	Iliopsoas	5	520.60	6
# R569	Abductor	5	339.65	6

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

PELVIS AND HIP

		Asst	Surg	Anae
	REDUCTION			
	Fractures			
	Coccyx			
UVC	- no reduction		visit fee	
# F115	- excision	5	208.80	5
	Pelvic ring			
UVC	- no reduction		visit fee	
# F134	- closed reduction	5	442.45	5
# F135	- open reduction	6	680.30	8
	Sacrum			
UVC	- no reduction		visit fee	
	Femoral neck trochanteric, subtrochanteric			
UVC	- no reduction		visit fee	
# F098	- closed reduction/traction	5	426.90	5
# F099	- open reduction - pin only	6	408.30	8
# F100	- open reduction - pin and plate/screws (cannulated included)	6	498.95	8
# F101	- open reduction - primary prosthesis, femur only (includes Moore, Thompson, Unipolar, Bipolar)	6	490.95	8
# R600	- delayed/staged graft	6	289.50	8
	Slipped epiphysis			
# R607	- closed reduction/traction	6	387.00	8
# R642	- closed reduction/internal fixation	6	387.00	8
# R627	- open reduction/fixation	6	580.90	8

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

PELVIS AND HIP

		Asst	Surg	Anae
	REDUCTION			
	Dislocations			
	Acetabulum			
UVC	- no reduction		visit fee	
# D052	- open reduction - lips	7	612.45	8
# D046	- open reduction - one pillar	5	967.90	10
# D047	- open reduction - two pillars	8	1451.45	12
	Hip			
# D042	- closed reduction		268.25	5
# D043	- open reduction	7	406.45	7
# R628	- late, after four weeks - open	7	774.90	10
	Note: May not be claimed with D042 at the same time.			
	Sacro-iliac			
# D059	- closed, traction, spica, etc.		428.50	5
# D060	- open reduction	5	593.00	5
	Sacro-coccygeal			
UVC	- closed reduction		visit fee	
# D061	- open, removal of coccyx	5	193.00	5
	Congenital hip			
# R404	- closed reduction (includes tenotomy and cast)		190.20	5
# R405	- repeat (includes cast)		131.80	5
# R406	- open reduction (includes tenotomy and arthrotomy)	7	472.35	7
Z291	Application Pavlik Harness or C.D.H. Splint		24.10	

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

FEMUR

		Asst	Surg	Anae
	AMPUTATION			
# R625	Gritti-Stokes or Callander	5	305.25	5
# R626	Through femur	5	306.30	5
	BIOPSY			
	Bone			
# Z869	- core, punch		39.10	5
# Z870	- x-ray control/general anaesthetic		97.35	5
# Z242	- open	5	193.00	5
	Soft tissue			
# Z228	- open		97.35	5
Z219	Muscle needle biopsy, soft tissue, per site		25.15	
# R256	Injection into bone cysts		117.00	
	INCISION AND DRAINAGE			
# R242	Bone	5	325.75	5
# R245	Sequestrectomy	5	395.25	5
# R243	Saucenzation and graft	5	619.90	6
# Z226	Soft tissue		97.35	5
	EXCISION			
	Bone			
# R314	Simple cyst/exostosis	5	225.50	5
	Bone tumour			
# R330	- simple	5	629.65	6
# R216	- with reconstruction/graft	8	1007.35	8
	Muscle			
# R522	- simple	5	193.00	5
# R523	- complex	5	484.35	6
	RECONSTRUCTION			
	Fascial			
# R632	- simple	5	193.00	5
# R633	- complex with or without synthetic graft or rotation flap	5	402.75	5

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

FEMUR

			Asst	Surg	Anae
	RECONSTRUCTION				
	Pseudoarthrosis				
# E048	- intramedullary nail with distal and proximal locking screws - femur	add		108.75	
# R328	Bone graft with or without external fixation		6	477.90	6
# R967	Circular external fixation		6	291.40	6
	Deformity				
# R262	Osteotomy femoral shaft		5	532.65	5
# R215	Osteotomy supracondylar		5	387.00	6
# R963	Single level correction - circular external fixation		5	638.40	5
# R964	Double level correction - circular external fixation		5	798.10	5
# R965	Bone transport - circular external fixation (less than or equal to 6 cm)		5	655.15	5
# R966	Bone transport - circular external fixation (greater than 6 cm)		5	763.80	5
	Leg Length Discrepancy				
# R333	Femoral shortening		5	480.70	5
# R332	Femoral lengthening		5	541.95	5
# R968	Lengthening with circular external fixation (less than or equal to 6 cm)		5	546.55	5
# R969	Lengthening with circular external fixation (greater than 6 cm)		5	763.80	5
# R340	Femoral epiphysiodesis		5	301.60	5
# R341	Tibial and femoral epiphysiodesis		5	426.90	5
# R343	Femoral stapling		5	313.65	5
# R344	Tibial and femoral stapling		5	387.00	5
	Muscles/Tendons				
	Quadriceps repair				
# R589	- simple		5	227.40	5
# R587	- reconstructive		5	387.00	5
# R530	Quadricepsplasty - all types		5	381.40	5
# R561	Ilio-tibial band		5	190.10	5
# Z197	Closed release of ilio-tibial band			49.20	5
	Tenotomy of hamstrings				
# R543	- single		5	168.85	5
# R562	- multiple		5	193.00	5
	Lengthening of hamstrings				
# R557	- single		5	223.65	5
# E050	- each additional	add		77.05	
# R571	Tendon or muscle transfer		5	307.15	5
# E049	- each additional	add		87.20	
# R524	Excision of myositis		5	289.50	5

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

FEMUR

			Asst	Surg	Anae
	REDUCTION				
	Fractures				
	No reduction				
UVC	- cast and bed rest			visit fee	
	Closed reduction				
F094	- traction - infant or child		5	258.00	5
# F095	- traction - adult or adolescent		5	407.35	5
# F097	- cast		5	258.90	5
# F096	- open reduction		6	493.80	8
	Femoral shaft/supracondylar				
# E048	- intramedullary nail with distal and proximal locking screws - femur	add		108.75	

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

KNEE

		Asst	Surg	Anae
	AMPUTATION			
# R625	Through knee - disarticulation	5	305.25	5
	ARTHRODESIS			
# R468	Knee	5	402.75	5
	ARTHROPLASTY			
# E564	- revision of arthroplasty	add 35%		
# R509	Patellar arthroplasty	5	241.60	5
	Hemiarthroplasty			
# R482	- single component (e.g. MacIntosh)	6	351.70	6
# R483	- double component (e.g. Marmar)	6	447.30	6
# R441	Total replacement/both compartments	8	619.90	8
# R248	Total knee replacement with take down of fusion	8	838.00	8
# R244	Revision total arthroplasty knee	8	838.00	8
# E598	- with associated patellar replacement or patelloplasty	add	94.60	
# R496	Removal of hemiarthroplasty - without replacement	5	242.25	5
# R497	Removal of total arthroplasty - without replacement	5	368.40	5

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

KNEE

		Asst	Surg	Anae
	ARTHROSCOPY			
# E595	- arthroscopy in association with surgery - same surgeon ... add		63.15	
# Z218	Diagnostic arthroscopy (sole procedure)	5	97.35	5
# R191	Synovial biopsy	5	43.60	5
# R192	Trimming of plica, tissue, meniscus	5	63.75	5
# R193	Removal of loose body, screw	5	192.00	5
# R194	Resection of plica	5	88.20	5
# R195	Lateral release	5	161.45	5
	Synovectomy			
# R196	- anterior, 1 compartment	5	130.85	5
# R197	- anterior, more than 1 compartment	5	262.60	5
# R198	- total, anterior and posterior	5	481.70	5
# R199	Drilling of defect (includes removal of loose body)	5	251.55	5
# R203	Pinning of osteochondral fragment	5	251.55	5
	Debridement			
# R204	- 1 compartment	5	251.55	5
# R205	- more than 1 compartment	5	326.55	5
# R206	Abrasion arthroplasty	5	288.60	5
# R207	Menisectomy	5	240.45	5
# R208	Repair medial or lateral meniscus	5	336.65	5

Note:
A maximum of 2 R codes may be billed in conjunction with E595 at any one sitting.

ARTHROTOMY

# R412	Knee - with or without removal of loose body	5	207.90	5
# R413	Osteochondritis dissecans with drilling and/or internal fixation	5	267.25	5

ASPIRATION

See Diagnostic and Therapeutic Procedures - Injections or Infusions.

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

KNEE

			Asst	Surg	Anae
	BIOPSY				
	Bone/joint				
Z870	- needle			97.35	5
# Z242	- open		5	193.00	5
# E563	- via arthroscope	add		11.10	
	Soft tissue				
# Z228	- open			97.35	5
Z219	Muscle needle biopsy, soft tissue, per site			25.15	
	DENERVATION/DECOMPRESSION				
# R426	Denervation of knee		5	258.00	5
# N285	Denervation of gastrocnemius		5	256.15	5
	INCISION AND DRAINAGE				
# Z226	Soft tissue			97.35	5
# R444	Joint		5	193.00	5
	EXAMINATION/MANIPULATION				
Z222	Manipulation - under general anaesthetic (see Surgical Preamble SP5)			24.10	5
	Note: Without general anaesthetic, see Diagnostic and Therapeutic Procedures - Physical Medicine.				
	EXCISION				
	Baker's cyst				
# R431	- simple		5	148.50	5
# R434	- extensive		5	264.50	6
# R501	Cysts of meniscus		5	126.25	5
# R429	Meniscectomy		5	241.30	5
# R417	Debridement of joint without synovectomy		5	290.55	5
# R424	Synovectomy		5	430.65	5
# R506	Prepatellar bursae		5	149.45	5
# R312	Patella - to include fascial repair		5	276.55	5
# R318	Excision exostosis/cyst patella		5	126.25	5

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

KNEE

		Asst	Surg	Anae
	RECONSTRUCTION			
	Meniscus			
# R508	Suturing of medial or lateral meniscus	5	242.25	5
	Muscles/Tendons			
	Tenoplasty			
# R584	- one	5	144.80	5
# E050	- each additional add		77.05	
	Suture of patellar or quadriceps tendon			
# R589	- early	5	227.40	5
# R587	- late	5	387.00	5
	Transplant of tendon			
# R571	- single	5	307.15	5
# E049	- each additional add		87.20	
	Tenotomy			
	- closed			
# Z237	- one		49.20	5
# Z238	- multiple		72.35	5
	- open			
# R564	- one	5	232.00	5
# R566	- multiple	5	253.30	5
# R516	Release patellar retinaculum	5	161.45	5
	Ligaments			
# R599	- simple - one	5	361.95	5
# R542	- extensive/multiple (including synthetics)	5	517.85	6
# E059	- revision/repair following previous reconstruction of knee ligaments to R542 add 30%			
# R484	- synthetic anterior/posterior cruciate	6	493.80	6
# R539	- removal of synthetics	5	213.45	5
	REDUCTION			
	Fractures			
	Patella			
# F085	- no reduction		67.75	
# F087	- open reduction or excision with or without repair	5	275.65	5
# F021	Osteochondral fracture - open reduction	5	327.00	5

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

KNEE

		Asst	Surg	Anae
	REDUCTION			
	Dislocations			
	Knee			
# D038	- closed reduction		207.90	5
# D039	- open reduction	5	309.00	5
	Patella			
	- closed reduction			
# D040	- without anaesthetic		62.20	
# D031	- with anaesthetic		97.35	5
	- open reduction			
# D041	- early		290.55	5
# R255	- late	5	484.35	6
# R403	- repair recurrent dislocation (includes inspection of joint)	5	393.40	5
# R515	Congenital dislocation - knee (open)	5	484.35	6

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

FIBULA AND TIBIA

		Asst	Surg	Anae
	AMPUTATION			
# R624	Tibia/fibula	5	306.30	5
	BIOPSY			
	Bone			
# Z870	- simple - punch		97.35	5
# Z242	- open	5	193.00	5
	Soft tissue			
# Z228	- open		97.35	5
Z219	Muscle needle biopsy, soft tissue, per site		25.15	
# R256	Injection into bone cysts		117.00	
	DECOMPRESSION/DENERVATION			
# R495	Decompression of fascial compartments	5	320.20	5
# Z783	Secondary closure		97.35	5
# Z251	Catheter insertion		49.20	
UVC	Monitoring of pressure monitoring device		visit fee	
# N184	Decompression of posterior tibial or common perineal nerve	5	165.20	5
	INCISION AND DRAINAGE			
# R237	Bone	5	308.10	5
# R239	Sequestrectomy	5	329.40	5
# R238	Saucerization and bone grafting	5	411.20	5
# Z226	Soft tissue		97.35	5
	EXCISION			
# R311	Exostosis/cyst	5	201.40	5
# R210	Fibular head	5	193.00	5
	Tumour			
# R295	- simple	5	289.50	5
# R253	- extensive with repair	5	648.20	6
# R246	Excision bony ridge to include interpositional materials	5	385.15	6
	Muscle/soft tissue			
# R522	- simple	5	193.00	5
# R523	- complex	5	484.35	6

FIBULA AND TIBIA

		Asst	Surg	Anae
	RECONSTRUCTION			
	Pseudoarthrosis			
# E041	- intramedullary nail with distal and proximal locking screws - tibia ... add		81.55	
# R326	Tibia/fibula	5	348.00	5
# R327	By-pass fibular graft	5	341.45	6
# R372	Congenital pseudoarthrosis	5	484.35	6
# R970	Circumferential external fixation	5	291.40	6
	Deformity			
# R289	Osteotomy tibia and fibula - adult or child	5	376.80	5
# R971	Single level correction - circular external fixation	5	510.35	5
# R972	Double level correction - circular external fixation	5	638.40	5
	Bone transport			
# R973	- circular external fixation (less than or equal to 6 cm)	5	634.70	5
# R974	- circular external fixation (greater than 6 cm)	5	763.80	5
# R403	Osteotomy repair recurrent dislocation (includes inspection of the joint)	5	393.40	5
	Leg Length Discrepancy			
# R331	Tibial lengthening	5	470.50	5
# R458	Tibial shortening	5	387.00	5
# R341	Tibial and femoral epiphysiodesis	5	426.90	5
# R339	Tibial epiphysiodesis	5	322.05	5
	Tibial stapling			
# R342	- one side	5	193.00	5
# R460	- both sides	5	242.25	5
# R344	Tibial and femoral stapling	5	387.00	5
# R975	Lengthening with circular external fixation (less than or equal to 6 cm)	5	438.00	5
# R976	Lengthening with circular external fixation (greater than 6 cm)	5	655.15	5
	REDUCTION			
	Fractures			
	Tibia with or without fibula			
# F078	- no reduction, rigid immobilization		115.95	
# F079	- closed reduction	5	180.05	5
# F080	- open reduction - shaft	5	356.40	5
	Intramedullary nail with distal and proximal locking screws			
# E041	- tibia ... add		81.55	
# F081	- medial or lateral tibial plateau	5	394.45	5
# E532	- both tibial plateaus, same knee ... add 50%			
	Fibula			
# F082	- no reduction, rigid immobilization		67.75	
# F083	- closed reduction		101.25	5
# F084	- open reduction	5	230.20	5

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

FOOT AND ANKLE

			Asst	Surg	Anae
	AMPUTATION				
# R620	Metatarsal/phalanx disarticulation		5	155.90	5
# E585	- each additional	add		47.30	
# R621	Ray (single)		5	217.15	5
# R623	Symes		5	285.80	5
# R622	Transmetatarsal/transtarsal		5	235.75	5
# R619	Terminal Symes		5	144.80	5
	ARTHRODESIS				
# R466	Ankle		5	389.75	5
# R552	- revision of arthrodesis		5	506.65	5
# R471	Interphalangeal		5	151.85	5
# E575	- each additional	add		41.70	
# R477	Metatarsophalangeal		5	247.25	5
# R474	Midtarsal/subtalar		5	370.85	5
# R513	Triple		5	423.80	5
# R475	Pan-talar, one stage		5	626.45	6
	ARTHROPLASTY				
# E564	- revision of arthroplasty	add 35%			
# R485	Ankle - total replacement		6	426.90	6
# R247	Revision total arthroplasty ankle		6	564.30	6
# R479	Removal of prosthesis without replacement		5	193.00	6
	Metatarsophalyngeal interposition				
# R456	- single		5	144.80	5
# E538	- each additional	add		38.00	
# R453	Metatarsophalyngeal (Swansons, etc.)		5	289.50	5
# R454	- multiple		5	387.00	6
# R500	Removal - prosthesis without replacement		5	144.80	5

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

FOOT AND ANKLE

			Asst	Surg	Anae
	ARTHROSCOPY				
# E595	- in association with surgery - same surgeon			63.15	
# Z218	Diagnostic arthroscopy (sole procedure)		5	97.35	5
# R211	Synovial biopsy		5	43.60	5
# R212	Removal of loose body, screw		5	192.00	5
# R213	Drilling of defect (includes removal of loose body)		5	251.55	5
	Debridement				
# R221	- local		5	251.55	5
# R224	- total		5	326.55	5
	Synovectomy				
# R230	- partial		5	196.60	5
# R232	- total		5	481.70	5
# R233	Pinning of osteochondral fragment		5	251.55	5

Note:
A maximum of 2 R codes may be billed in conjunction with E595 at any one sitting.

ARTHROTOMY

Ankle

# R503	- removal of loose body, etc.		5	167.10	5
# E539	- with osteotomy of malleolus	add		117.85	
# R504	Midtarsals		5	144.80	5
# R505	Metatarsal/phalangeal		5	144.80	5

ASPIRATION

See Diagnostic and Therapeutic Procedure - Injections or Infusions.

BIOPSY

Bone

Needle

Z869	- punch			39.10	5
# Z870	- under general anaesthetic			97.35	5
# Z242	- open		5	193.00	5

Joint

# R409	- open			168.00	5
# E563	- via arthroscope	add		11.10	

Soft tissue

# Z228	- open			97.35	5
Z219	Muscle needle biopsy, soft tissue, per site			25.15	

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

FOOT AND ANKLE

			Asst	Surg	Anae
	INCISION AND DRAINAGE				
# R220	Bone		5	227.40	5
# Z226	Bursae			97.35	5
# R503	Joints		5	167.10	5
# Z228	Soft tissue - open			97.35	5
# R201	Sequestrectomy		5	193.00	5
# R202	Saucerization and bone graft		5	387.00	5
	EXAMINATION/MANIPULATION				
Z222	Manipulation - under general anaesthetic (see Surgical Preamble SP5)			24.10	5
	Note: Without general anaesthetic, see Diagnostic and Therapeutic Procedures - Physical Medicine				
	Club foot, etc. - manipulation and cast/strapping				
Z235	- without anaesthetic			19.45	
E584	- application of plaster cast outside hospital	add		11.15	
# Z224	- with anaesthetic			39.00	5
	EXCISION				
	Bone				
# R299	Phalanx		5	127.15	5
# R309	Metatarsal head		5	175.45	5
# E587	- each additional	add		41.70	
# R305	Accessory navicular (scaphoid)		5	155.90	5
# R302	Bunion/bunionette		5	150.30	5
# R307	Calcaneal spur		5	139.25	5
# R282	Exostosis (dorsal, subungual)		5	100.15	5
# R308	Os calcis, talus		5	283.95	5
# R301	Sesamoid, one or both		5	142.00	5
# R306	Tarsal bar		5	230.20	5
# R266	Tumour (foot)		5	241.30	5
	Joint				
# R420	Ankle synovectomy		5	273.75	5
	Metatarsophalangeal synovectomy				
# R425	- one		5	226.40	5
# R414	- two or more		5	339.65	5

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

FOOT AND ANKLE

			Asst	Surg	Anae
	EXCISION				
	Soft Tissue				
# R549	Ganglion - simple or complex		5	177.80	5
# R506	Bursa		5	149.45	5
# R551	Fascia for Dupuytrens - partial or complete		5	322.15	5
	Muscle				
# R522	- simple		5	193.00	5
# R523	- complex		5	484.35	6
	RECONSTRUCTION				
	Pseudoarthrosis				
# R363	Malleoli		5	296.05	5
# R321	Tarsals/metatarsals/phalanx		5	260.75	5
	Deformity				
	Osteotomy				
# R259	- os calcis		5	297.85	5
# R276	- metatarsals and phalanx		5	144.80	5
# E596	- each additional	add		41.70	
# R277	- midtarsal/tarsal		5	242.25	5
	Shortening metatarsal				
# R337	- one		5	225.50	5
# R338	- two or more		5	272.80	5
# R977	Circular external fixation without osteotomy*		5	583.75	5
# R978	Circular external fixation with osteotomy*		5	729.45	5
# R979	Circular external fixation with multiple osteotomies*		5	911.30	5
	Note: * This requires the application of tibial apparatus.				
	Forefoot				
# R430	Claw and hammer toe		5	151.25	5
# E594	- each additional hammer toe	add		41.70	
	Hallux Valgus				
# R304	- e.g. Mayo, Keller		5	217.15	5
# R355	- e.g. Joplin, McBride		5	267.25	5
# R360	Major forefoot reconstruction, must include the first MP joint and a minimum of 2 other MP joints		5	459.45	5
# R446	Overlapping 5th toe		5	136.35	5
	Club Foot				
# R408	Posterior or medial release		5	312.70	5
# R448	Posteromedial release, lateral shortening, tendon transfers and fusion		5	371.20	5
# R313	Complex reconstruction or revision of previous club foot repair (not to include simple tendon releases)		5	468.65	5
# R546	Plantar fascia release (Steindler)		5	165.20	5

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

FOOT AND ANKLE

			Asst	Surg	Anae
	RECONSTRUCTION				
	Ligaments				
	Ankle				
# R597	- one		5	301.60	5
# R548	- extensive/multiple		5	511.45	5
	Tendons				
# R640	Exploration - tendon sheath		5	126.25	5
	Tenolysis - extensive release				
# R556	- one		5	202.25	5
# E599	- each additional digit	add		87.20	
	Tendon transfer foot and ankle				
# R565	- single		5	253.30	5
# E055	- each additional	add		94.60	
# R572	Tenodesis		5	258.90	5
# R560	Graft		5	253.30	5
# E053	- each additional	add		94.60	
	Lengthening or shortening				
# R557	- one		5	223.65	5
# E050	- each additional	add		77.05	
	Suture extensor tendon				
# R578	- one		5	164.10	5
# E580	- each additional	add		70.95	
	Suture flexor tendon				
# R585	- one		5	307.60	5
# E581	- each additional	add		128.95	
	Achilles tendon repair				
# R589	- early		5	227.40	5
# R587	- late		5	387.00	5
	Tenotomy - open				
# R579	- one toe			87.20	5
# R581	- more than one toe			193.00	5
	Tenotomy - closed				
# Z229	- one toe			49.20	5
# Z243	- more than one toe			97.35	5
	Achilles or tibialis anterior/posterior tenotomy				
# R544	- open		5	171.70	5
# R555	- closed			132.70	5

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

FOOT AND ANKLE

			Asst	Surg	Anae
	REDUCTION				
	Fractures				
	Ankle				
# F074	- no reduction - rigid immobilization			67.75	
# F075	- closed reduction		5	144.80	5
	- open reduction				
# F076	- one malleolus		5	237.50	5
# F077	- multiple malleoli or ligaments		5	311.85	5
	Ankle fracture with tibial Plafond burst				
# F104	- closed reduction		5	242.25	5
# F108	- open reduction		5	362.95	6
	Metatarsus				
F061	- one or more			49.20	
F062	- with rigid immobilization			67.75	
	- closed reduction				
F063	- one or more		5	98.35	5
E584	- application of plaster cast outside hospital	add		11.15	
	- open reduction				
# F064	- one		5	178.20	5
# F065	- two or more		5	249.65	5
	Os calcis				
F070	- no reduction - rigid immobilization			97.35	
F071	- closed reduction			161.45	5
E584	- application of plaster cast outside hospital	add		11.15	
	- open reduction				
# F072	- with repair of both the subtalar and calcaneocuboid joints		5	394.15	5
	Phalanx				
F056	- no reduction - rigid immobilization			49.20	
E584	- application of plaster cast outside hospital	add		11.15	
E560	- each additional	add		12.05	
F058	- closed reduction - one			72.35	5
E584	- application of plaster cast outside hospital	add		11.15	
E561	- each additional	add		14.90	
# F060	- open reduction		5	172.30	5

MUSCULOSKELETAL SYSTEM
SURGICAL PROCEDURES

FOOT AND ANKLE

			Asst	Surg	Anae
	REDUCTION				
	Fractures				
	Tarsus excluding os calcis				
F066	- no reduction - rigid immobilization			98.10	
F067	- closed reduction		5	165.20	5
E584	- application of plaster cast outside hospital	add		11.15	
# F068	- open reduction		5	237.50	5
	Intra-articular fracture - I.P. Joint				
F057	- closed reduction			77.95	
E584	- application of plaster cast outside hospital	add		11.15	
# F059	- open reduction		5	144.80	5
	Dislocations				
	Ankle				
# D035	- closed reduction		5	111.35	5
# D036	- open reduction		5	252.45	5
# R402	- recurrent dislocation and/or subluxation		5	367.45	5
	Interphalangeal				
D027	- closed reduction			57.50	5
E584	- application of plaster cast outside hospital	add		11.15	
E578	- each additional	add		10.25	
# D029	- open reduction		5	151.25	5
	Metatarsophalangeal				
D030	- closed reduction			57.50	5
E584	- application of plaster cast outside hospital	add		11.15	
E579	- each additional	add		10.25	
# D032	- open reduction		5	163.35	5
	Tarsus				
D033	- closed reduction			147.60	5
E584	- application of plaster cast outside hospital	add		11.15	
# D034	- open reduction		5	252.45	5

RESPIRATORY SURGICAL PROCEDURES

NOSE

		Asst	Surg	Anae
Z298	Nasopharynx (to include oropharynx, oral cavity and hypopharynx) EUGA of nasopharynx for malignant disease including biopsies (not to be claimed if done in conjunction with T & A, adenoidectomy or quadroscopy)		41.25	5
	Excision of nasopharyngeal or oropharyngeal lesion			
# R181	- with palatal split	5	508.20	7
R182	- with mandibulotomy, glossotomy and/or palatal split	7	987.65	10
Z297	Insertion of prosthesis for nasal septal perforation		18.30	
	ENDOSCOPY			
	Fiberoptic endoscopy of upper airway (nose, hypopharynx or larynx)			
Z296	- with flexible endoscope - if only operative procedure performed		18.30	
Z299	- with rigid endoscope for diagnostic evaluation or to facilitate biopsy or surgical treatment of pathology in the posterior nasal cavity, hypopharynx or larynx		8.55	
# Z317	Examination under anaesthesia (EUA) of nose including suction cautery for posterior epistaxis unilateral or bilateral		112.05	6
# Z306	Excision of middle turbinate concha bullosa - unilateral		55.60	5
	INCISION			
# Z301	Drainage of abscess or haematoma		55.60	5
# Z302	Turbinate reduction - uni- or bilateral (to include cautery, cryosurgery, turbinectomy)		55.60	5
	EXCISION			
	Nasal polyp			
Z304	- single		21.00	
# Z305	- multiple or involving general anaesthetic (unilateral)		55.60	5
	Choanal polypectomy			
# Z308	- unilateral		55.60	5
	Biopsy			
# Z309	- single		18.30	
# Z310	- multiple or involving general anaesthetic		50.90	5
	Removal of foreign body			
# Z311	- simple		10.55	
# Z312	- complicated, or involving general anaesthetic		50.90	5
# M010	Excision of intranasal lesions by lateral rhinotomy approach	5	493.90	7
# M011	Excision of other intranasal lesions (see General Preamble GP12)	I.C	I.C	I.C

RESPIRATORY SURGICAL PROCEDURES

NOSE

RECONSTRUCTION

			Asst	Surg	Anae
# M012	Septoplasty (when intranasal ethmoidectomies or antrostomies are done in addition, add 50% of the appropriate fees to M012, M013, M014, M015, M016, M019, M024)			252.15	5
# E840	- with repair of septal perforation	add		119.20	
# M013	Partial septorhinoplasty (excluding osteotomies)			360.45	7
# E840	- with repair of septal perforation	add		119.20	
# M014	Septorhinoplasty			484.15	7
# M019	- with autologous bone or cartilage graft - from site other than nose		5	690.35	7
# M024	- with non-autologous graft or implant		5	542.75	7
# E840	- with repair of septal perforation	add		119.20	
# E642	- if performed by external approach using transverse columellar and rim incisions with elevation of nasal tip skin flap, to M012, M013, M014, M019, M024	add		119.20	
# R319	Graft to nose - autologous, bone or cartilage (without septorhinoplasty)		5	360.45	5
# R320	- non-autologous or prosthetic implant (without septorhinoplasty)		5	232.00	5

Note:
M013, M014, M019, M024, R319, R320 - claims for these procedures require Ministry of Health and Long-Term Care authorization. (see Surgical Preamble, paragraph 16)

# M015	Septodermoplasty (to include fascial and other grafts)			306.85	5
# M016	Repair of septal perforation			358.70	5
# M017	Packing for localization of cerebrospinal rhinorrhea			39.60	5
# E603	- with fluorescein injection	add		50.90	
# M033	Closure or opening of nostril for atrophic rhinitis			254.15	5
# M018	Endonasal augmentation for atrophic rhinitis - unilateral (including obtaining graft or preparing implant)			306.85	5
# M020	Repair of choanal atresia - uni- or bilateral		5	360.45	5
# M021	Puncture and insertion of tube for choanal atresia - uni or bilateral			123.70	5
# M028	Dilation of choanal atresia - uni- or bilateral			73.80	5

RESPIRATORY SURGICAL PROCEDURES

NOSE

		Asst	Surg	Anae
	RECONSTRUCTION			
	Rhinoplasty for reconstruction of cleft lip - nasal deformity			
# M030	- complex, to include necessary grafts and septoplasty	5	618.45	7
# M032	- tip and septum to include total take down of cleft lip		432.45	6
# M031	- tip and septum reconstruction to include minor lip repair (Minor revision, Z-plasty)		254.15	5

Note:
M030, M031, and M032 are not to be billed with repair of cleft lip

TREATMENT OF EPISTAXIS (NASAL HAEMORRHAGE)

Z314	Cauterization - unilateral		11.50	5
Z315	Anterior packing - unilateral		15.35	5
Z316	Posterior packing - uni - or bilateral		35.50	5
# M027	Ligation of external carotid artery - unilateral	6	297.25	6
# R788	Ligation of internal maxillary artery - unilateral	7	408.10	10
# R789	Ligation of anterior ethmoidal artery - unilateral	6	299.85	6
# Z313	Endoscopic transnasal ligation of the sphenopalatine artery for posterior epistaxis - unilateral		123.70	

RESPIRATORY SURGICAL PROCEDURES

ACCESSORY NASAL SINUSES

		Asst	Surg	Anae
	Antrum or sinus lavage			
# Z319	Antral puncture and/or lavage - unilateral or bilateral		43.15	5
	Note: When a physician submits a claim for performing any insured surgical procedure on the same patient on the same day as the physician submits a claim for rendering Z319, the Z319 service is included (in addition to the common elements) as a specific element of that other insured service.			
	Maxillary			
# M054	- intranasal antrostomy - unilateral	5	123.70	5
# M055	- Caldwell-Luc (intranasal antrostomy included) - unilateral	5	247.35	5
	Maxillectomy			
# M056	- partial or complete	7	776.70	10
# E947	- with orbital exenteration	add	306.85	
# Z318	Frontal trephine or sinusotomy		133.30	5
# M058	Radical frontal sinusectomy		460.20	5
# M063	Coronal and/or osteoplastic procedure for frontal sinusectomy, reconstruction or obliteration - unilateral or bilateral	7	716.25	10
	External frontal-ethmoidal sinusectomy and/or reconstruction			
# M059	- unilateral	5	460.20	6
	Intranasal ethmoidectomy			
# M060	- unilateral		158.25	5
# E980	- when performed endoscopically	add	41.25	
	External or transantral ethmoidectomy			
# M023	- unilateral (to include Caldwell-Luc with transantral approach)	5	360.45	5
# M061	Trans-septal sphenoidotomy or sphenoid sinusectomy		355.65	5
# M064	External transethmoidal sphenoidotomy or sphenoid sinusectomy	7	612.65	10
	Closure of antral fistula			
# M066	- minor		98.80	5
# M067	- complex or involving general anaesthetic (to include Caldwell-Luc if necessary)		345.15	5

RESPIRATORY SURGICAL PROCEDURES

LARYNX

			Asst	Surg	Anae
	ENDOSCOPY				
	Laryngoscopy				
# E600	- using operating microscope - to charges for laryngoscopy	add		33.60	
	Direct				
# Z321	- with or without biopsy			61.30	6
# Z322	- with removal of foreign body			106.45	6
# Z323	- with removal of lesion(s)			148.60	6
# Z343	- with dilatation of larynx, to include bronchoscopy if necessary			202.35	6
	Indirect				
# Z324	- with biopsy or removal of foreign body			35.50	6
	INTRODUCTION				
# M080	Teflon augmentation larynx			182.10	6
	EXCISION				
	Laryngectomy				
# M081	- total		6	838.90	13
# E882	- with hemi thyroidectomy	add		177.40	
# E883	- with subtotal thyroidectomy	add		266.60	
# E884	- with total thyroidectomy	add		374.00	
# M082	Laryngofissure		6	444.80	8
	Note: Excision to include laryngoscopy.				
	Laryngectomy				
# M084	- segmental, including reconstruction		6	888.85	9
# M085	Arytenoidectomy or arytenoidopexy or lateralization procedure		6	395.05	8
	REPAIR (TO INCLUDE LARYNGOSCOPY)				
# M090	Laryngoplasty - e.g. repair of stenosis and fractures, transections - not to be billed with M084			642.45	6
# M089	Creation of tracheo-oesophageal fistula		5	197.45	5
# Z320	Insertion of voice prosthesis			25.85	
# Z303	Removal of laryngeal stent or keel			103.60	5

RESPIRATORY SURGICAL PROCEDURES

TRACHEA AND BRONCHI

Asst | Surg | Anae

PREAMBLE

1. When laryngoscopy and bronchoscopy or oesophago-bronchoscopy are carried out as combined procedures, the physician should claim for one or the other but not both.

2. No claim should be made for bronchoscopy carried out immediately following thoracic surgery under the same anaesthetic by the same surgeon.

3. If bronchoscopy has been performed by the same physician on a patient in the 3-week period preceding a major lung resection, the amount payable for bronchoscopy performed the same day as the major lung resection (including intraoperatively) is reduced to nil.

ENDOSCOPY

Bronchoscopy

# Z327	- with or without bronchial biopsy, suction or injection of contrast material		nil	112.55	6
# E632	- with removal of foreign body	add		64.55	2
# E633	- with dilatation of stricture	add		44.55	
# E634	- with selective endobronchial blocker or catheter insertion	add		44.55	
# E635	- with palliative endobronchial tumour resection including laser or cryotherapy	add		64.55	
# E636	- with broncho-alveolar lavage for obtaining specimens suitable for differential cellular analysis (for assessment of interstitial lung disease)	add		24.80	
# E637	- with selective brushings of all 18 segmental bronchi for occult carcinoma in situ; specimens labeled as to site	add		69.30	
# E638	- with transbronchial lung biopsy under image intensification only	add		74.30	
# E622	- any bronchoscopic procedure for patients under 3 years of age	add		79.40	2
# E677	- transbronchial needle aspiration (TBNA) of mediastinal and/or hilar lymph nodes	add		94.30	
# E678	- TBNA of lung mass	add		94.30	
# Z342	Limited bronchoscopy with placement of endobronchial blocker and/or double lumen tube			112.55	
# Z359	Repeat bronchoscopy for tracheobronchial toilet when performed within one week of another bronchoscopic procedure			51.00	6

Quadroscopy or panendoscopy

# Z355	- with or without biopsy (nasopharyngoscopy, laryngoscopy, bronchoscopy, oesophagoscopy with or without gastro-duodenoscopy) using separate instruments in search of malignant disease			182.00	6

RESPIRATORY SURGICAL PROCEDURES

TRACHEA AND BRONCHI

			Asst	Surg	Anae
	TRACHEO-BRONCHIAL ASPIRATION				
# Z344	First procedure			37.05	
# Z345	Subsequent procedures performed by same physician			18.60	
	Note: Not to apply to: 1. operating surgeons, 2. when respiratory unit fees apply, or 3. within the first two hours post-operatively				
# Z326	Change of tracheostomy tube			11.25	
# Z346	Transtracheal aspiration			22.35	
# Z356	Closure of persistent tracheostoma			133.95	6
	INCISION				
# Z741	Tracheotomy		5	156.90	6
# E639	- with anterior cricoid split	add		78.50	
# Z738	Insertion of Montgomery "T" Tube or similar laryngeal or tracheal stent		5	216.10	8
	EXCISION				
E623	- repeat operation after 30 days	add		415.15	
# M099	Segmental resection of cervical trachea		9	812.25	10
# E631	- with resection of cricoid	add		314.20	
# M103	Segmental resection of trachea with either sternotomy or thoracotomy		9	1294.20	13
# M104	Carinal resection (without pulmonary resection)		11	825.40	15
	REPAIR				
# M100	Tracheal rupture, transcervical		9	654.30	10
# M101	Tracheal-bronchial rupture, transthoracic		9	868.15	13

RESPIRATORY SURGICAL PROCEDURES

CHEST WALL AND MEDIASTINUM

			Asst	Surg	Anae
	EXCISION				
# M105	Chest wall tumour, resection of 2 or 3 ribs or cartilages		9	517.40	13
	Chest wall reconstruction				
# E640	- after chest wall resection where a significant defect (minimum 5 cm in diameter) remains requiring repair with synthetic material	add		179.55	
# E601	- for each additional rib (more than 3) to a maximum of 3 additional	add		57.50	
# E602	- with sternal resection	add		177.95	
# M107	Total sternectomy		9	812.25	13
# N284	Excision of first rib and/or cervical rib to include scalenotomy when required		6	408.00	6
# M106	Mediastinal tumour		9	649.90	13
# M108	Ligation of thoracic duct - as sole procedure		6	410.45	6
	REPAIR				
	Chest wall - pleura				
# M109	- closed (see General Preamble GP12)			IC	5
# M110	- open (see General Preamble GP12)			IC	13
# M116	- fixation for trauma		5	350.00	6
# E604	- for fixation of each additional rib exceeding four ribs	add		55.60	2
# M117	Sternal fixation for trauma		5	251.45	6
# R352	Pectus excavatum or carinatum repair (by reconstruction, not implant)		6	690.45	11
	SURGICAL COLLAPSE				
	Thoracoplasty				
# M111	- one stage		9	304.20	10
# E605	- for each additional rib (more than 3) to a maximum of 3 additional	add		55.60	
# Z742	Phrenicotomy		5	106.45	5

RESPIRATORY SURGICAL PROCEDURES

CHEST WALL AND MEDIASTINUM

		Asst	Surg	Anae
	INCISION			
# Z353	Incisional biopsy of chest wall tumour	5	89.45	5
# Z354	Excisional biopsy of rib for tumour	5	142.20	6
# Z357	Thoracic window creation	5	228.25	7
# Z358	Thoracic window closure	5	111.20	6
	ENDOSCOPY			
# Z329	Mediastinoscopy	5	187.30	6
# Z330	- with bronchoscopy	5	248.15	6
# Z333	- with transbronchial biopsy under image intensification (including bronchoscopy)	5	275.25	6
# Z328	- with mediastinotomy	5	274.65	6
# Z348	- with bronchoscopy and mediastinotomy	5	349.70	6
	Anterior mediastinotomy			
# Z347	- when sole procedure performed	5	198.10	6

RESPIRATORY SURGICAL PROCEDURES

LUNGS AND PLEURA

			Asst	Surg	Anae
	INTRODUCTION - THORACENTESIS				
Z331	Aspiration for diagnostic sample			25.15	
Z332	Aspiration with therapeutic drainage with or without diagnostic sample			45.85	5
E606	- administration of chemotherapy or sclerosing agent	add		23.25	
E542	- when performed outside hospital	add		11.15	
# Z334	Total unilateral lung lavage with or without bronchoscopy using Double Lumen Tube and single lung anaesthesia			304.60	13
	ENDOSCOPY				
# Z335	Thoracoscopy (pleuroscopy) with or without pleural biopsy, suction, etc.			111.20	5
	INCISION				
# Z340	Biopsy of lung, needle			91.90	5
# Z336	Biopsy of pleura, needle - including diagnostic aspiration			45.85	5
# Z341	Closed drainage effusion or pneumothorax			62.85	5
# E606	- with administration of chemotherapy or sclerosing agent	add		23.25	
# Z337	Rib resection for drainage		6	126.75	6
# M133	Thoracotomy for removal of foreign body		9	390.65	13
# M137	Thoracotomy with or without biopsy		9	390.65	13
# M134	Thoracotomy for post-operative haemorrhage or empyema		9	390.65	13
# M132	Thoracotomy with repair of ruptured diaphragm		9	507.45	13
# M130	Closure of broncho-pleural fistula (transthoracic or trans-sternal)		9	584.75	13
# E609	- with intercostal muscle bundle	add		121.70	
# E610	- with myovascular flap (pectoralis major, latissimus dorsi, rectus abdominus)	add		263.80	
# M135	Major decortication of lung for empyema or tumour		11	593.60	15
# Z339	Intercostal drainage with insufflation of sclerosing agent under general anaesthesia		5	182.90	6

CARDIOVASCULAR SURGICAL PROCEDURES

HEART AND PERICARDIUM

			Asst	Surg	Anae
	Re-operation involving open heart procedures with pump				
# E670	- following previous thoracotomy	add		224.70	
# E671	- following previous sternotomy	add		337.00	
	Note: More than one month after original operation.				
	Cardiac massage				
# R765	- open		13	231.30	13
	Note: For closed massage - see Critical Care - Diagnostic and Therapeutic Procedures.				
# Z433	Replacement of pacemaker pack (single or multiple leads)			146.45	5
# Z444	Insertion of permanent endocardial electrode and implantation of pack, includes insertion of temporary transvenous lead at same surgical procedure by same surgeon		5	323.75	5
# Z445	Repositioning of permanent endocardial electrode (as separate procedure)			323.75	5
# Z435	Insertion of permanent endocardial electrode(s)			154.10	
# Z436	Exposure of vein and implantation of pack			166.55	5
# R752	Atrio-ventricular sequential pacemaker with permanent atrial and ventricular endocardial electrodes		5	454.55	5
# R751	Implantation of epicardial electrode(s) plus implantation of pack		6	465.00	20
# Z429	Implantation of coronary sinus lead for biventricular pacing		5	299.25	8
	Implantation of ventricular assist device				
# R701	- uni-ventricular		18	721.60	28
# R702	- bi-ventricular		18	1334.80	28
# Z412	Replacement or repair of pacemaker lead		5	110.75	5
# Z428	Pacemaker lead extraction, including the use of extraction sheathes, with or without laser or similar technology		10	598.50	7
# E628	- each additional lead extraction	add		194.50	
	Implantation of cardioverter (CD) defibrillator				
# R753	- by thoracotomy		6	720.30	20
# R761	- by transvenous approach		5	587.35	8
	Note: Induction of ventricular arrhythmia at time of CD implant payable at 85%. See note re: G259 in Diagnostic and Therapeutic Procedures.				
# Z415	Removal and/or replacement of implantable cardioverter defibrillator		5	339.45	5

CARDIOVASCULAR SURGICAL PROCEDURES

HEART AND PERICARDIUM

			Asst	Surg	Anae
	Thoracotomy				
# M137	- with or without biopsy		9	390.65	13
# M134	- for post-operative haemorrhage		9	390.65	13
# Z401	Aspiration of pericardium			131.70	
# Z414	Injection of pericardial sclerosing agents			23.10	
# R750	Open biopsy of pericardium and drainage (transthoracic or epigastric)		13	317.85	13
	Pericardiectomy				
# R748	- one side open		13	635.45	20
# R749	- both sides open or sternal split		13	1001.40	20
	Cardiotomy				
# R712	- with exploration		18	525.75	20
# R713	- with removal of foreign body		18	635.45	20
# R714	- with removal of tumour		18	525.75	20
# E660	- epicardial E.P.S. mapping	add		185.15	
# E661	- endocardial E.P.S. mapping	add		185.15	
# E658	- HIS Bundle ablation	add		278.10	
# R711	Division of accessory conduction pathway (to include cardiotomy, mapping with or without HIS bundle)			741.55	20
# R709	Atrial ablative procedure for surgical treatment of atrial arrhythmia (either Cox-Maze procedure or performed using an energy source)		18	741.55	20
# R710	Resection/ablation for ventricular tachycardia (to include cardiotomy, mapping with or without HIS bundle)			1112.15	20
	EXCISION				
# R920	Ventricular tumour		18	712.15	28
# R746	Ventricular aneurysm		18	864.50	28
# R747	Aneurysm of sinus of Valsalva		18	783.55	28
# R741	Coronary artery endarterectomy and/or gas endarterectomy		18	730.70	20
# E651	- when done in conjunction with coronary artery repair	add		202.05	

Note:
R741, E651 - for multiple or complex procedures, assessment by the Medical Consultant is available and may be requested

# E648	- excision of extensive endocardial scar, to ventriculotomy or aneurysm repair	add		135.80	
	Coronary artery repair				
# R742	- one		18	895.55	20
# R743	- two		18	1202.45	20
# E654	- each additional	add		187.70	

Note:
Where a single segment of vein is used for more than 2 anastomoses, the second and subsequent anastomoses are to be claimed at 50% of the E654 fee

CARDIOVASCULAR SURGICAL PROCEDURES

VALVES

		Asst	Surg	Anae
# R724	Pulmonary valvotomy	18	663.10	28
# R725	Pulmonary valvotomy and infundibular resection	18	758.80	28
# R772	Pulmonary valve replacement	18	758.80	28
# R726	Tricuspid valvotomy	18	778.25	20
# R727	Tricuspid annuloplasty	18	662.55	20
# R728	Tricuspid valve replacement	18	758.80	28
# R729	Mitral valvotomy	18	717.25	20
# R730	Mitral valvotomy - restenosis	18	798.80	20
# R734	Mitral annuloplasty	18	770.70	20
# R735	Mitral replacement	18	933.55	28
# R733	Mitral valvoplasty	18	963.40	28
	Mitral valve reconstruction			
# R773	- simple (includes annuloplasty)	18	1618.50	28
# R774	- complex (includes annuloplasty and repair of both the anterior and posterior leaflets)	18	2021.05	28
# R930	Aortic valvoloplasty	18	837.70	28
# R736	Aortic valvotomy	18	707.85	20
# R737	Aortic infundibular resection (ventriculomyotomy)	18	869.70	28
# R738	Aortic valve replacement	18	1010.55	28
# E647	- patch aortoplasty with pericardium or graft, to R738 and/or aortic annuloplasty	add	264.70	
# E656	- aortic annuloplasty (reconstruction and enlargement of aorticannulus), to R738 and/or patch aortoplasty	add	288.85	
# R863	Replacement of aortic valve, replacement of ascending aorta, and reimplantation of coronary arteries (Modified Bentall)	18	2021.05	28
# R876	Valve sparing aortic root replacement or remodelling	18	2021.05	28

Note:
Multivalvular replacement - the fee will be that for the major valve replaced plus 85% of the fee for the additional valve or valves.

CARDIOVASCULAR SURGICAL PROCEDURES

ARTERIES

		Asst	Surg	Anae
	Cannulation for infusion chemotherapy			
# R775	- superficial temporal artery	5	95.80	5
# R776	- hepatic artery	6	212.15	6
# R778	- carotid artery	5	148.50	5
# R760	Regional isolation perfusion e.g. iliac	10	410.45	10
# R764	Exploration of major artery	6	271.60	10
	INCISION			
# Z402	Arteriotomy		117.30	5
	Note: Z402 not allowed in addition to other major cardiovascular surgery			
	REPAIR			
	Traumatic			
# R790	Suture of lacerated major artery	5	316.85	10
# R795	Repair of lacerated major artery or microscopic repair of digital artery (including patch angioplasty)	10	498.65	10
# R862	- by bypass or interposition graft	10	662.15	10
	LIGATION			
# R781	Ligation of artery - as sole procedure	5	170.10	8
# R788	Internal maxillary artery - Caldwell Luc approach	7	408.10	10
# R789	Anterior ethmoid artery	6	299.85	6
# R708	Internal iliac artery (unilateral or bilateral)	7	409.55	10

CARDIOVASCULAR SURGICAL PROCEDURES

ARTERIES

Asst | Surg | Anae

EXCISION AND/OR REPAIR

1. Common femoral artery repair (e.g. R784, R785) includes repair to the profunda femoris artery as far as the first major branch.

2. If the repair extends beyond the first major branch of the profunda femoris artery, R815 may be claimed in addition.

3. If the repair extends beyond the second major branch of the profunda femoris artery, R856 instead of R815 may be claimed in addition.

4. For procedures involving the application of a complete aortic cross clamp, the anaesthetic basic fee will depend on:

   a. the level of application of the cross clamp;

   and

   b. the surgical exposure and extent of the aortic repair.

# E679	- with vein graft harvest remote from site of by-pass and only when saphenous vein is unavailable	add	124.10

CARDIOVASCULAR SURGICAL PROCEDURES

ARTERIES

			Asst	Surg	Anae
# R875	Endovascular aneurysm repair using stent grafting		10	1330.40	17

Note:
This service includes insertion of all catheters including access catheters, interpretation of any images which may be taken at the time of the procedures and all variations of a single stent graft.

Abdominal surgical exposure

# R880	- supraceliac aortic cross clamp			-	20
# R881	- infraceliac aortic cross clamp			-	17
# R882	Thoracic surgical exposure			-	25
# R883	Thoraco-abdominal surgical exposure			-	30
# R815	Arterioplasty with or without patch graft including microvascular anastomosis, arterial or venous (other than listed below)		10	527.75	10

Carotid

# R792	- endarterectomy		10	764.55	10
# R796	- carotid body tumour		10	769.85	10
# R798	- aneurysm - reconstruction or excision with graft		10	820.70	10

Aortic arch reconstruction

# R830	- innominate		10	867.35	10
# R831	- subclavian		10	867.35	10
# R832	- vertebral		10	867.35	10
# E659	- with thoracotomy	add	5	169.00	7
# E667	- ruptured	add		266.60	3

Thoracic aorta aneurysm - repair or excision with graft

# R799	- ascending		10	1455.30	20
# R800	- arch		10	1807.10	20
# R801	- descending with or without temporary shunt		10	1260.30	20
# E667	- ruptured	add		266.60	3
# R803	Thoraco-abdominal aneurysm		18	2444.50	30

Note:
If the services of a second anaesthetist are required, the second anaesthetist is also permitted to claim R803C.

Abdominal aorta

# R802	- aneurysm		10	1197.10	17
# R816	- plus unilateral common femoral repair		10	1303.70	17
# R817	- plus bilateral common femoral repair		10	1408.70	17
# E626	- plus implantation of inferior mesenteric artery	add		174.35	
# E627	- ruptured	add		317.75	3

CARDIOVASCULAR SURGICAL PROCEDURES

VEINS

		Asst	Surg	Anae
	EXCISION			
	Resection of AV aneurysm or fistula with or without major graft			
# R825	- major aneurysm	10	975.50	17
# R826	- minor aneurysm	10	497.25	10
	LIGATION			
# Z745	Saphenous		53.20	5
# Z746	Femoral	5	74.25	5
# Z747	Popliteal	5	74.25	5
# Z748	Internal jugular	5	148.60	5
# R839	Internal iliac	6	394.85	10
# R834	I.V.C. - transabdominal	6	446.50	10
# R838	I.V.C. - transvenous (umbrella)	6	303.00	10
# R868	High ligation and stripping of long saphenous vein with groin dissection	5	148.60	5
# R869	Stripping of short saphenous vein with popliteal dissection	5	107.50	5
# R837	Multiple ligation and avulsion	5	148.60	5
# R844	Recurrent varicose veins - multiple ligation and/or stripping	5	353.80	5
# R842	Extra fascial and sub-fascial incompetent perforators by full fascial technique	5	384.75	6
# E653	- plus stripping	add	127.15	

CARDIOVASCULAR SURGICAL PROCEDURES

VEINS

		Asst	Surg	Anae
	REPAIR			
# R820	Lacerated major vein e.g. femoral, popliteal, vena cava, axillary, sub-clavian, brachial or microscopic repair of digital vein	5	317.55	5
# R818	- including patch	10	497.25	10
# R819	- by vein graft	10	661.30	10
# R835	S.V.C. bypass graft	7	758.40	17
# R836	Pulmonary embolectomy	18	866.55	20
# R828	Ilio-femoral thrombectomy with or without femoral vein ligation	10	446.50	10
# E657	- plus I.V.C. ligation ..... add		446.50	
# R829	Thrombectomy, other than above	7	302.80	10
# R865	Distal spleno-renal shunt	10	1259.55	10
	ANASTOMOSIS			
# R822	Porto-caval	10	919.10	10
	Spleno-renal			
# R823	- abdominal approach	10	1117.90	10
# R821	- transthoracic approach	10	1117.90	13
# R824	Meso-caval	10	866.55	10
# R827	Creation of A.V. fistula	5	360.25	6
# R841	Obliteration of A.V. fistula		82.55	5
# R833	Ligation or removal of by-pass graft		82.55	5

HAEMATIC AND LYMPHATIC SURGICAL PROCEDURES

SPLEEN AND MARROW

INCISION

		Asst	Surg	Anae
# Z404	Splenic puncture and aspiration		81.00	5
# Z403	Bone marrow aspiration		33.90	
# Z408	Bone marrow core biopsy (with biopsy needle)		63.35	5

Note:

1. If Z403 and Z408 are both performed through the same site or with the same biopsy needle, only Z408 is eligible for payment. Maximum of 1 Z408 per patient, per day.
2. If the aspiration does not result in any material for examination, the service is not eligible for payment.

[Commentary:
If Z408 and Z403 are performed through different sites, both services are payable.]

Bone marrow transplantation - team fee

# Z425	- aspiration from donor		506.75	8
# Z426	- infusion into recipient		62.55	

[Commentary
Bone marrow transplantation is not an insured benefit for treatment of some conditions. Please refer to ministry of Health and Long-Term Care Medical Consultant for qualifying diagnoses.]

Note:
Bone marrow interpretation: see Diagnostic and Therapeutic Procedures - Laboratory Medicine.

EXCISION

# R905	Splenectomy - partial or complete	7	493.90	7
# E793	- laparoscopic or laparoscopic assisted, to R905	add 25%		

HAEMATIC AND LYMPHATIC SURGICAL PROCEDURES

LYMPH CHANNELS

		Asst	Surg	Anae
	ANASTOMOSIS			
# R846	Micro lympho - lympho or lymphovenous	7	691.40	7
	INCISION			
# Z410	Drainage of sub-fascial abscess		74.50	5
# Z413	Scalene node fine needle aspiration		28.40	
	EXCISION			
	Cystic hygroma			
# R907	- unilateral	5	408.65	6
	Neck			
# R910	- limited, e.g. sub mandibular supra omohyoid	6	271.05	6
# R911	- radical	6	843.35	8
# R915	- modified radical including functional with preservation of spinal accessory nerve	6	906.45	8
# R912	Ileoinguinal, radical resection	6	489.30	8
	Axillary or inguinal node			
# R913	- radical resection - unilateral	5	367.95	6
# R914	- limited resection	5	207.30	5
	BIOPSY			
# Z405	Anterior cervical, axillary, inguinal	5	62.95	5
# Z406	Scalene, posterior cervical	5	125.85	5
# Z578	Multiple para-aortic lymph nodes	6	75.00	6
	Percutaneous retro peritonea			
# Z407	- one group	5	87.15	5
# Z409	- two or more groups	5	130.80	5
# R916	Re-exploration of vascular graft and closure of lymph fistula in groin	5	207.30	6

DIGESTIVE SYSTEM SURGICAL PROCEDURES

ORAL CAVITY AND PHARYNX

Note:
To include nasopharynx, oropharynx, hypopharynx except where otherwise specified.

		Asst	Surg	Anae
	INCISION			
# Z506	Drainage of oral abscess or haematoma		50.90	5
# Z510	Drainage of pharyngeal abscess or haematoma		91.10	5
# Z524	Drainage of haematoma or deep neck abscess (external approach)	5	271.05	5
Z501	Biopsy		35.50	
E542	- when performed outside of hospital add		11.15	
# Z537	- requiring general anaesthetic		76.70	5
	Tongue tie, release of			
Z111	- simple		15.35	
# Z112	- complex or requiring general anaesthetic		50.90	5
# S031	Palatal fenestration		197.55	5
	EXCISION			
	Lesion			
Z502	- less than 2 cms	5	71.00	5
S003	- 2 to 4 cms, inclusive	5	212.80	6
S006	- over 4 cms	5	342.30	6
E542	- when performed outside of hospital add		11.15	
S004	Ranula	5	165.80	5
S005	Composite resection of lesion of oral cavity and/or oropharynx with partial resection of mandible	10	897.45	12
S007	Extended composite resection of lesion of oral cavity and oropharynx with partial resection of mandible and resection of maxilla	10	1059.45	12
# S050	Cryotherapy for treatment of pre-malignant or malignant lesions of oral cavity or sinuses		148.60	5
	Glossectomy			
# S018	- partial	6	197.45	8
# S019	- complete	6	281.95	8
# Z109	Wedge excision of lesion		61.30	5
# S020	Glossoplasty	5	197.45	5
	Extraction of tooth (complete care)			
S023	- single		24.90	6
E700	- each additional tooth add		13.40	
# S028	Dentigerous cyst	5	98.80	5

DIGESTIVE SYSTEM SURGICAL PROCEDURES

ORAL CAVITY AND PHARYNX

			Asst	Surg	Anae
# S900	Basic units for anaesthesia with any unlisted dental surgical procedure performed by dental or oral surgeon (see General Preamble GP58, also Bulletin #4203)				8
# S021	Repair of extensive laceration (see General Preamble GP12)		5	I.C	I.C
	Note: For minor lacerations - see Skin.				
# S034	Cleft palate repair		6	369.25	8
# S035	Removal of sutures under general anaesthesia			41.25	5
# S032	Bone graft to palate		6	335.65	8
	Closure of fistula				
# S030	- anterior alveolar		5	197.45	5
# S033	- palate		6	281.95	8
# S036	Uvulopalatopharyngoplasty (includes tonsillectomy)			239.75	6
# S069	Pharyngoplasty		8	360.45	8
# S002	Excision of parapharyngeal space lesions (with mobilization of parotid gland)		5	612.65	8
# S067	Partial pharyngectomy - transthyroid or lateral		8	791.00	11
# S068	Pharyngo-laryngectomy		8	1155.45	14
# E882	- with hemithyroidectomy	add		177.40	
# E883	- with subtotal thyroidectomy	add		266.60	
# E884	- with total thyroidectomy	add		374.00	
	Branchial				
# S058	- cleft lesion		5	306.85	5
# S059	- repeat procedure		5	435.30	5
# S061	Thyroglossal duct remnant		5	306.85	5
# S062	- repeat procedure		5	410.40	5
# S063	Tonsillectomy and may include adenoidectomy			178.35	5
# S065	Adenoidectomy			101.25	5
	Secondary suture or cauterization following tonsillectomy and/or adenoidectomy				
# S066	- when haemorrhage occurs after initial procedure			59.50	5
# S024	Excision of torus palatinus		5	197.45	5

DIGESTIVE SYSTEM SURGICAL PROCEDURES

SALIVARY GLANDS AND DUCTS

		Asst	Surg	Anae
	INCISION			
# Z500	Sialolithotomy		30.65	
# Z521	- requiring general anaesthesia	5	103.60	5
	EXCISION			
# S042	Submandibular gland or sublingual gland	5	287.75	5
	Parotid gland			
# S043	- total (with preservation of facial nerve)	6	690.90	8
# S044	- total (without preservation of facial nerve)	6	593.00	8
# S045	- subtotal (with preservation of facial nerve)	6	642.35	7
# S047	- repeat subtotal (with preservation of facial nerve)	6	690.90	7
# S046	- subtotal (without preservation of facial nerve)	6	395.45	6
# Z522	Excision small tumour	5	51.25	5
	RECONSTRUCTION			
# S049	Plastic repair of duct	5	202.25	5
Z511	Dilation and/or probing of duct		30.65	5
# S057	Submandibular duct relocation	6	360.75	6

DIGESTIVE SYSTEM SURGICAL PROCEDURES

LIPS

			Asst	Surg	Anae
	INCISION				
# Z503	Biopsy			35.40	5
E542	- when performed outside of hospital	add		11.15	
	EXCISION				
	Wedge resection of lip				
# S011	- vermilion		5	98.45	5
# S010	- with plastic repair			239.00	5
Z504	Excision of lesion		5	61.15	5
E542	- when performed outside of hospital	add		11.15	
# S012	Lip shave vermilionectomy		5	201.70	5
	RECONSTRUCTION				
	Cleft lip				
# S013	- unilateral		6	363.30	8
# E501	- with nasal cartilage realignment	add		304.30	
# S014	Reconstruction with lip switch flap		6	444.40	8
# S015	Complex reconstruction or revision of previous repair and excision (see General Preamble GP12)			I.C	I.C

DIGESTIVE SYSTEM SURGICAL PROCEDURES

ENDOSCOPIC ULTRASOUND

			Asst	Surg	Anae
	Radial or linear probe through endoscope				
# E800	- to endoscopy fee	add		101.50	
# E801	- including biliary and/or pancreatic examination, to endoscopy fee	add		152.30	

Note:
The amount payable for E800 when rendered in conjunction with E801 is zero.

			Asst	Surg	Anae
	Linear or radial echo-endoscope				
# S236	- excluding biliary or pancreatic examination (scope also used for therapeutic procedures)	nil		203.05	5
# S237	- including biliary and/or pancreatic examination (scope also used for therapeutic procedures)	nil		253.80	5
# E802	- biopsy or fine needle aspiration, to a maximum of 3, per lesion	add		50.75	
# E803	- dilation of stricture	add		30.65	
# E804	- injection of one or more of any of the following - metastases, nodes, masses, or celiac plexus	add		145.05	
# E805	- drainage of pseudocyst (including stent insertion if performed)	add		203.05	

Note:

1. The amount payable for S236 when rendered in conjunction with S237 is zero.
2. The amount payable for upper and/or lower GI endoscopy rendered in conjunction with S236 or S237 is zero unless the upper and/or lower GI endoscopy is required due to the limited visualization with the linear or radial echo-endoscope.

DIGESTIVE SYSTEM SURGICAL PROCEDURES

OESOPHAGUS

For procedures on the oesophagus, the following basic units for assistants and anaesthesiologists will apply except if a basic fee is listed.

		Asst	Surg	Anae
# S073	Cervical approach	6	-	7
# S074	Thoracic approach	10	-	13
# S075	Abdominal approach	7	-	8

ENDOSCOPY

# Z515	Oesophagoscopy, with or without biopsy(ies)		68.25	5
	Oesophagoscopy-gastroscopy, with or without duodenoscopy			
# Z399	- elective	nil	102.75	5
# Z400	- for active bleeding	nil	125.10	5
# E696	- with dilatation of oesophagus	add	30.65	
# E702	- with multiple (3 or more) biopsies of specific lesion	add	15.10	
# E690	- with removal of foreign body(ies)	add	43.85	
# E795	- with brushing of oesophagus, stomach, and/or duodenum	add	46.30	
# E770	- with duodenoscopy and drainage of bile after I.V. CCK stimulation	add	23.10	
# E692	- with laser debulking	add	69.70	
# E698	- with pneumatic or balloon dilation	add	69.70	
# E703	- with snare polypectomy first polyp (> 1 cm)	add	50.50	
# E799	- each additional polyp, by snare polypectomy (> 1 cm) (to a maximum of 2)	add	25.25	
# E695	- laser palliation of oesophageal tumour, extensive, complete obstruction (see General Preamble GP12)	add	I.C	
# E797	- management of uncomplicated upper or lower gastrointestinal bleeding, by any technique (e.g. laser, injection, diathermy, banding etc.)	add	46.30	
# E798	- management of complicated upper gastrointestinal bleeding by any technique in haemodynamically unstable patients with active bleeding during endoscopy	add	69.70	
# E629	- endoscopic placement of stent in duodenum	add	137.05	

DIGESTIVE SYSTEM SURGICAL PROCEDURES

RECTUM

			Asst	Surg	Anae
	ENDOSCOPY				
	Sigmoidoscopy with or without anoscopy				
Z535	- with rigid scope			36.80	5
Z536	- with biopsy(ies)			44.55	5
Z592	- with decompression of volvulus			49.40	5
E746	- when Z535, Z536 or Z592 performed outside hospital	add		5.85	
# E641	- endoscopic placement of stent in rectum	add		137.05	
# E797	- management of uncomplicated upper or lower gastrointestinal bleeding, by any technique (e.g. laser, injection, diathermy, banding etc.)	add		46.30	
	Note: Z535 not to be billed with Z555 or Z580.				
	EXCISION				
	Proctectomy				
# S213	Anterior resection or proctosigmoidectomy (anastomosis below peritoneal reflection)		8	776.80	8
# S214	Abdomino-perineal resection or pull through		8	935.75	10
	Two surgeon team				
# S215	- abdominal surgeon		8	776.80	10
# S216	- perineal surgeon			284.75	
# S217	Hartmann procedure		8	650.90	9
# S218	Colon reconstruction following Hartmann procedure		8	763.30	8
# Z752	Biopsy of rectosigmoid or above for Hirschsprung's disease		5	82.35	5
# E710	- each additional biopsy	add		45.55	
# S222	Presacral or trans-sacral proctotomy and excision of lesion		5	350.65	6
	Polyps or tumours of rectum or sigmoid *				
# Z753	- electrocoagulation - base under 2 cm			24.25	5
# Z754	- excision - base under 2 cm		5	82.35	5
# Z784	- excision and suture - base 2 to 5 cm, inclusive		5	213.50	5
# Z785	- excision and suture - base over 5 cm		5	329.65	5
# Z755	- electrocoagulation - base 2 to 5 cm, inclusive		5	142.40	5
# Z761	- electrocoagulation - base over 5 cm		5	219.90	5
# E688	- with laser debulking	add		69.80	

Note:

1. * To a maximum of 2, any size or technique.
2. For fulguration or excision of tumours through the colonoscope, use codes Z570, Z571 (page S13).

DIGESTIVE SYSTEM SURGICAL PROCEDURES

RECTUM

			Asst	Surg	Anae
	REPAIR				
# S223	Anastomosis of rectum		5	488.20	6
	Rectal prolapse				
# S225	- excision of mucous membrane		5	239.20	5
# S226	- perineal repair - major		5	356.50	5
# S227	- abdominal approach		6	554.10	8
# S228	- insertion of Thiersh wire		5	190.85	5
	SUTURE				
# S229	Suture of rectum, trauma-external approach		5	239.20	5
	Closure of fistula				
# S231	- rectovaginal (any repair)		5	338.55	6
# S525	- rectovesical		5	446.90	6
	MANIPULATION				
# Z541	Dilation and/or disimpaction or removal of foreign body under general anaesthetic (as sole procedure)			58.15	5
# Z756	Fecal disimpaction - no anaesthetic			36.80	

Note:
The fees for excision, ligation, injection of haemorrhoids and treatment of intra or perianal condylomata acuminata include anoscopy.

	ENDOSCOPY				
Z543	Anoscopy (proctoscopy)			6.25	
	INCISION				
# Z544	Biopsy			34.90	5
Z545	Thrombosed haemorrhoid(s)			25.25	5
E542	- when performed outside hospital	add		11.15	
# S241	Sphincterotomy(ies)		5	88.20	5
# S242	- with excision of fissure(s)		5	162.70	5

DIGESTIVE SYSTEM SURGICAL PROCEDURES

RECTUM

		Asst	Surg	Anae
	EXCISION			
# S246	Excision of fissure(s)	5	122.05	5
# S247	Haemorrhoidectomy, with or without sigmoidoscopy or repair of fissure(s) and/or sphincterotomy and/or anal dilation	5	224.25	5
# Z565	Complete haemorrhoidectomy using cryotherapy and/or Barron ligation(s) including rectal dilation		94.85	5
# Z546	Barron ligation(s) (not to exceed 6 in any one year)	nil	27.05	
# Z566	Barron ligation(s) plus cryotherapy (not to exceed 6 in any one year)	nil	34.90	
# S249	Local excision for malignancy	5	153.05	5
Z757	Excision of benign anal lesion(s)	5	40.65	5
E542	- when performed outside hospital add		11.15	
# S251	Fistula-in-ano	5	213.15	5
	INJECTION			
Z575	Haemorrhoid injections (to a maximum of 6 per year)		27.05	
Z576	Injections for anal fissure		35.90	5
	REPAIR			
# S253	Low imperforate anus repair	7	406.85	7
# S260	High imperforate anus repair (supra-levator)	7	900.75	7
# S256	Excision of scar, for stenosis	5	142.40	5
# S257	Anoplasty, for stenosis	5	275.05	5
# S258	Repair of anal sphincter	5	275.05	5
# S259	Repair of anal sphincter and ano-rectal ring	5	356.50	5
	DESTRUCTION			
Z548	Cauterization of fissure		34.90	5
	Fulguration of condylomata			
Z549	- local anaesthetic		30.95	
# Z758	- general anaesthetic	5	84.20	5
	MANIPULATION			
Z550	Dilation of anal sphincter		12.05	5
# S248	Peter Lord procedure		43.60	5

DIGESTIVE SYSTEM SURGICAL PROCEDURES

LIVER

			Asst	Surg	Anae
	INCISION				
	Biopsy				
# Z554	- incisional			82.35	
# Z551	- needle			70.80	5
# S268	Insertion of implantable pump for continuous liver perfusion		7	604.95	7
	EXCISION				
	Hepatectomy				
# S269	- local excision of lesion (less than 5 cm)		7	350.65	7
# S275	- partial lobectomy (excision greater than 5 cm)		8	585.05	8
	Formal anatomical resection				
# S270	- one or two liver segments		12	1184.60	12
# S267	- three or four liver segments		12	1652.15	12
# S271	- five or more liver segments		12	1784.60	12
# S272	Laparotomy, cholangiogram and biopsy (neonatal jaundice)		6	387.40	6
	Liver transplant				
# E765	- with reconstruction or repair of the hepatic artery (i.e re-anastomosis or conduit), to liver transplant fee	add		300.45	
# S274	- donor		6	964.50	8
# S294	- recipient		20	2748.75	30
# S295	Repeat liver transplant		30	3776.20	40

Note:
Cholecystectomy is not eligible for payment when claimed with liver lobectomy.

	REPAIR				
# S273	Marsupialization and/or decompression of cyst(s) or abscess(es)		7	350.65	7
# E715	- more than three cysts or abscess(es)	add		74.90	

			Asst	Surg	Anae
	PARACENTESIS				
	Aspiration				
Z590	- for diagnostic sample			25.25	
Z591	- with therapeutic drainage with or without diagnostic sample			46.50	5
E724	- administration of chemotherapy or sclerosing agent	add		23.25	
Z763	Paracentesis with lavage for diagnosis			38.70	5
E542	- when performed outside hospital, to Z590, Z591 or Z763	add		11.15	
	INCISION				
# Z563	Needle biopsy of peritoneum			38.70	
# Z564	Open lavage of peritoneal cavity for diagnosis without manual exploration of peritoneal cavity			73.60	5
# S312	Laparotomy, with or without biopsy or for Hirschsprung's disease (except biopsies of stomach, liver, pancreas and multiple para-aortic lymph nodes)		6	305.05	6

Note:

1. S312 - use for division or removal of adhesions, if no other abdominal surgery performed - may not be claimed with other intra-abdominal procedures (except for IOP).
2. Omentectomy for tumour debulking - professional assessment by the Ministry of Health and Long-Term Care Medical Consultant is available and may be requested.

# E745	- insertion of tubes and post-operative continuous peritoneal lavage when combined with any other abdominal procedure	add		94.85	
	Laparotomy				
# S321	- for acute trauma		6	397.15	6
# E733	- with repair of intestine - single	add		142.40	3
# E734	- multiple and/or with resection	add		211.15	3
# E735	- with splenectomy (partial or complete)	add	4	284.75	3
# E736	- with repair of lacerated liver	add	4	187.90	3
# E739	- with repair of diaphragm	add	4	122.05	2
# E723	- with repair of lacerated spleen	add	4	284.80	3
# E693	- with repair of ruptured bladder	add	4	-	3
# E694	- with nephrectomy	add	4	-	3

DIGESTIVE SYSTEM SURGICAL PROCEDURES

ABDOMEN, PERITONEUM AND OMENTUM

		Asst	Surg	Anae
	INCISION			
	Peritoneal abscess			
# S313	- subphrenic	7	370.95	7
# S314	- abdominal	6	264.45	6
# Z569	Pelvic abscess, incision and drainage - rectal or vaginal approach		122.05	5
# Z594	Percutaneous abdominal abscess drainage including daily supervision, for one or more abscesses within the same abdominal quadrant or the pelvis		232.50	
# E686	- within each other abdominal quadrant, or the pelvis (if the initial abscess was not in the pelvis) add		116.20	
Z595	- replacement of drainage catheter in abdominal abscess add		43.60	
# Z57-	Removal of infected sutures from abdominal wall or re-exploration of wound for bleeding - general anaesthetic	5	94.85	5
# S311	Umbilical vein intra-abdominal dissection and catheterization	6	232.50	6
	Note: For vascular newborn - see Diagnostic & Therapeutic Procedures - Vascular Cannulation.			
# S320	Insertion of antabuse into abdominal wall		58.15	
	Insertion of peritoneo-jugular shunt for ascites			
# S203	- primary	7	281.85	7
# S209	- revision	7	208.15	7
	EXCISION			
# S316	Excision of full thickness abdominal wall tumour and primary closure (see General Preamble GP12)		I.C	6
# S317	Umbilectomy - plastic	5	111.45	5
	Panniculectomy			
# S318	- includes any necessary diastasis repair	6	435.90	6
# E748	- with repair of umbilical hernia add		122.05	
# S319	Mesenteric cyst	6	335.15	6
	Note: S318 Panniculectomy requires Ministry of Health and Long-Term Care authorization (see Surgical Preamble SP4).			
	ENDOSCOPY			
	Peritoneoscopy, culdoscopy or laparoscopy			
# Z552	- without biopsy	5	131.45	6
# Z553	- with biopsy and/or lysis of adhesions and/or removal of foreign body and/or cautery of endometrial implants	5	173.25	6

DIGESTIVE SYSTEM SURGICAL PROCEDURES

ABDOMEN, PERITONEUM AND OMENTUM

			Asst	Surg	Anae
	REPAIR				
# S325	Omentopexy - as sole operative procedure		6	305.05	6
	Herniotomy				
	Inguinal and/or femoral				
# S322	- infants		5	284.75	5
# S326	- children		5	251.20	5
# S323	- adolescents and adults		5	284.75	5
	Unilateral with exploration of other side				
# S328	- infants and children		5	329.30	5
	Strangulated or incarcerated				
# S329	- without resection of bowel		5	366.15	5
# S330	- with resection of bowel		6	660.50	7
	Umbilical				
# S332	- adolescent or adult		5	284.75	5
# S333	- child (operative)		5	222.75	5
# E764	- umbilical hernia repair when done in conjunction with other abdominal surgery, to other surgery	add		96.85	
# E756	- with resection of strangulated contents	add		111.45	2
# E757	- without resection of strangulated contents	add		55.25	1
	Omphalocele and gastrochisis				
# S334	One stage - repair		7	375.80	7
	Multiple staged - repair				
# S335	- gross method or Silon mesh		7	370.95	7
# S336	- second stage repair (completion of abdominal wall closure)		7	370.95	7
	Diaphragmatic other than oesophageal hernia				
	One stage procedure				
# S337	- trans-abdominal		7	508.55	9
# S338	- trans-thoracic		9	508.55	13
# S339	- second stage and abdominal closure		5	295.40	9
# S340	Ventral - post-operative		6	370.95	6
# S344	Massive incisional hernia		6	416.50	6
# S345	Massive sliding inguinal hernia		6	350.65	6
# E725	- recurrent - all types, except oesophageal	add	4	87.15	2
# E726	- repeat recurrent inguinal hernia (more than 2 repairs), to S322, S323, S326, S329, S330	add	4	152.10	2
# S342	Epigastric		5	239.20	5
# E727	- hydrocele - extra - applicable to adults only	add		65.90	
	SUTURE				
# S343	Secondary closure for evisceration - sole operative procedure in abdomen		6	275.05	6

NOT ALLOCATED

UROGENITAL AND URINARY SURGICAL PROCEDURES

BLADDER

		Asst	Surg	Anae
	INTRODUCTION			
	Catheterization			
	Acute retention, change of Foley catheter or suprapubic tube or instillation of medication			
Z602	- office		8.55	
Z603	- home		16.25	
# Z611	- hospital		8.55	
	Note: Z611 may not be claimed in conjunction with pelvic or genito-urinary surgery.			
Z608	Manual catheter declotting and irrigation of bladder		58.65	
	INCISION			
Z605	Aspiration		12.50	
# S478	Cystotomy or cystostomy	5	215.80	5
# Z480	Cystotomy with trochar and cannula and insertion of tube		85.30	5
# E750	- when done in conjunction with another procedure add		26.05	
# S481	Cystolithotomy - when sole operative procedure	5	260.65	5
# S476	Cutaneous vesicostomy	5	437.20	5
# S477	Reduction cystoplasty (bladder plication)	5	356.70	5
	EXCISION			
	Cystectomy			
# S482	- partial for tumour or diverticulum (single or multiple)	6	381.60	6
# S483	- with reimplantation of ureter	6	552.30	7
# S490	- with reimplantation of ureters	6	733.50	7
# S484	- complete cystectomy, without transplant	6	657.75	10
# S485	- with ureterointestinal transplant	8	984.65	13
# S453	- with ureteroileal conduit	9	1250.30	15
# S440	- complete cystectomy with Koch pouch urinary diversion	9	1475.70	15
	Note: S482 not to be billed in addition to S451.			
# S441	Creation of Koch pouch urinary diversion	9	1013.45	15
# S471	Excision of urachal cyst or sinus with or without umbilical hernia repair	6	296.30	6
# S487	Excision of urachus, repair of bladder and diversion of urine	6	296.30	6

UROGENITAL AND URINARY SURGICAL PROCEDURES

BLADDER

		Asst	Surg	Anae
	EXCISION			
	Extrophy - excision of bladder and repair of abdominal wall			
# S488	- inclusive of graft	6	215.80	6
# S489	- above including bilateral ureterosigmoidostomy	6	657.75	6
# S491	Plastic repair of extrophy using bladder and including skin flaps	6	657.75	6
	REPAIR			
# S512	Repair of ruptured bladder	5	330.90	6
# S513	Cystoplasty, using intestine	8	657.75	9
	Plastic repair of bladder neck			
# S518	- child	5	331.70	5
# S519	- adolescent or adult	5	437.20	5
# S520	- with diverticulectomy	5	552.30	7
	DESTRUCTION			
# S521	Litholapaxy and removal of fragments		215.80	5
	SUTURE			
	Closure of fistula			
# S522	External, suprapubic	5	260.85	5
	Vesicovaginal			
# S523	- vaginal approach	5	435.20	6
# S524	- transvesical approach (with or without omental flap)	5	467.00	6
# S525	Vesicorectal or vesicosigmoid	5	446.90	6

Note:
Closure of fistula see also S734, S711 Operations on the Female Genital System.

UROGENITAL AND URINARY SURGICAL PROCEDURES

URETHRA

		Asst	Surg	Anae
	ENDOSCOPY			
	Urethroscopy			
# Z617	- diagnostic		35.50	5
# Z618	- with biopsy		77.70	5
# S547	Removal of foreign body or calculus		170.65	5
	INCISION			
# Z616	Biopsy of urethra (without endoscopy)		23.55	5
	Urethrotomy			
# S530	- external	5	215.80	5
# S532	- transurethral (visual)	5	166.05	5
# S538	- repeat procedure within 6 months by same surgeon	5	95.75	5
# S531	Urethrostomy	5	215.80	5
# Z604	Meatotomy and plastic repair		31.60	5
# S533	For extravasation of urine with multiple drainage	5	215.80	5
# S534	- above with external urethrotomy or cystotomy	5	331.70	5
# Z609	Periurethral abscess		31.60	5
	EXCISION			
# S536	Caruncle	5	85.30	5
# S537	Urethral papilloma, single or multiple		85.30	5
# S541	Diverticulectomy - male or female	5	260.85	5
# S542	Posterior urethral valve	5	331.70	5
# S543	Prolapse urethra	5	85.30	5
# S544	Urethrectomy - radical	5	215.80	5
	REPAIR			
# S548	Urethral sling	5	381.60	6
	Retropubic urethropexy for stress incontinence			
# S549	- primary procedure	5	301.35	6
# S546	- repeat procedure for failed retropubic or vaginal surgery for stress incontinence	5	353.90	6
	Note: See also S731-S733, Operations on the Female Genital System for stress incontinence.			
# S559	Prosthetic procedure for urinary incontinence (e.g. Kauffman, Rosen type etc.)	5	381.60	5
# S560	- where perineum has been previously operated on for incontinence	5	437.20	5
# S563	Removal of perineal incontinence prosthesis	5	143.75	5

UROGENITAL AND URINARY SURGICAL PROCEDURES

URETHRA

		Asst	Surg	Anae
	REPAIR			
# S539	Insertion of inflatable prosthesis at bladder neck with or without urodynamic control	5	776.70	6
# S540	Revision or removal of inflatable prosthesis at bladder neck	5	239.75	5
	Urethroplasty			
	First stage			
# S545	- posterior	5	381.60	6
# S550	- anterior	5	293.35	5
# S558	Second stage	5	235.35	5
# S535	One stage repair and may include skin grafting	5	381.60	6
	SUTURE			
# S551	Rupture, anterior urethra (diversion of urine extra)	5	170.65	5
	Posterior urethra			
# S552	- immediate repair	5	437.20	5
# S553	- late repair	5	552.30	5
	Fistula			
# S554	- penile urethra (diversion of urine extra)		92.10	5
# S555	- perineal urethra	5	325.95	5
# S556	Rectourethral with diversion, colostomy and closure of colostomy	6	552.30	7
	DESTRUCTION			
# S557	Urethrovesicolysis - when sole operative procedure	5	215.80	5
# S564	Transurethral incision or resection of external sphincter - when sole operative procedure		325.95	5
	MANIPULATION			
	Dilatation of stricture			
Z621	- male, local anaesthetic		13.65	
# Z619	- male, general anaesthetic		52.70	5
	Dilatation of urethra			
Z622	- female		5.65	
# Z620	- female, general anaesthetic		41.65	5
# Z615	Filiform and follower urethral dilation and may include bladder catheterization		59.75	5

Note:
Z619, Z620, Z621, Z622 payable at nil if claimed with Z615.

MALE GENITAL SURGICAL PROCEDURES

PENIS

			Asst	Surg	Anae
	INCISION				
	Slit of prepuce (complete care)				
# S567	- newborn			14.35	
# S568	- infant			21.50	5
# S569	- adult or child			30.25	5
	EXCISION				
	Circumcision - for physical symptomatology only				
# S573	- for patients aged one year or older		5	90.05	5
# S577	- for infants less than one year of age		5	90.05	5

Note:

1. Circumcision is an insured service only when medically necessary. As such, circumcision performed for ritual, cultural, religious or cosmetic reasons at any age is not an insured service.
2. Circumcision for neonatal phimosis is not an insured service.

Z702	Biopsy			23.55	5
E542	- when performed outside of hospital	add		11.15	
	Amputation				
# S574	- partial		5	170.65	5
# S575	- partial with inguinal glands 1 or 2 stages		5	437.20	5
# S576	- radical with inguinal and femoral glands 1 or 2 stages		6	552.30	7
	Condylomata				
Z701	- local anaesthetic			32.60	
# Z767	- general anaesthetic			78.60	5
# S599	Excision plaque for Peyronies disease		5	210.95	5

Note:
Where grafting is necessary, appropriate skin graft fee is payable with S599.

	REPAIR				
	Hypospadias or Epispadia				
	One stage repair				
# S578	- with meatus to but not into glans		5	287.75	5
# S571	- with advancement of meatus into glans		5	383.50	5
# S572	- into glans using island flap pedicle (penoscrotal)		5	662.45	6
# S579	Chordee repair		5	215.80	5
# S580	Plastic reconstruction, urethra		5	331.70	5
# S581	Closure urethro-cutaneous fistula			92.10	5
# S597	Penile prosthesis for impotence		5	306.85	5
# E755	- with inflatable prosthesis	add		55.15	
# S588	Surgical removal of prosthesis		5	110.15	5
# S566	Revision including removal of prosthesis		5	239.75	5
Z700	Intracorporeal injection for impotence			27.80	

MALE GENITAL SURGICAL PROCEDURES

TESTIS

		Asst	Surg	Anae
	INCISION			
# Z703	Abscess		55.15	5
	BIOPSY			
# Z704	Single		55.15	5
# Z705	Bilateral		83.35	5
# Z706	- with vasography		120.80	5
	Note: See also Diagnostic Radiology - GU Tract			
	Orchidectomy			
# S589	- unilateral	5	170.65	5
# S590	Radical removal lymph nodes for testicular tumour	6	834.25	8
	Radical orchidectomy for malignancy			
# S598	- unilateral	5	235.35	5
	REPAIR			
	Orchidopexy			
# S591	- for undescended testis, any type, one or two stages to include hernia repair where required	5	331.70	5
# S592	- second stage (Torek) repair		55.15	5
# S593	Exploration for undescended testicle, without orchidopexy	5	260.85	5
# S600	Reduction of torsion of testis or appendix testis and orchidopexy (one or both sides) if required	5	235.35	5
# S595	Ruptured testicle	5	170.65	5

MALE GENITAL SURGICAL PROCEDURES

EPIDIDYMIS AND TUNICA VAGINALIS

		Asst	Surg	Anae
	EPIDIDYMIS			
# Z707	Incision of abscess		55.15	5
# S601	Spermatocele or spermatic granuloma excision	5	170.65	5
	Epididymectomy			
# S602	- unilateral	5	170.65	5
	TUNICA VAGINALIS			
Z708	Hydrocele aspiration		16.25	
# S611	Hydrocele excision - unilateral	5	170.65	5

Note:
Hydrocele excision rendered with hernia repair is claimed as E727.

MALE GENITAL SURGICAL PROCEDURES

SCROTUM

		Asst	Surg	Anae
	INCISION			
	Abscess or haematocele			
Z709	- local anaesthetic		20.10	
# Z768	- general anaesthetic		55.15	5
# S616	- and exploration - unilateral	5	85.30	5
	EXCISION			
# S618	Resection of scrotum	5	215.80	5
	SUTURE			

Note:
For suture of lacerations, refer to the general listings under Integumentary System Surgical Procedures - Skin and Subcutaneous Tissue - Suture of Lacerations. Where suture of lacerations is the sole procedure and is done under general anaesthesia, refer to code E530.

MALE GENITAL SURGICAL PROCEDURES

VAS DEFERENS

		Asst	Surg	Anae
	INCISION			
# Z710	Vasography		55.15	5
	REPAIR			
	Vasovasostomy and/or vasoepididymostomy			
# S623	- unilateral	5	215.80	5
S625	- including biopsy and vasography	5	260.85	5

Note:
To include microscopic control if required.

	SUTURE			
	Vasectomy			
S626	- uni - or bilateral - by any technique	nil	107.40	5
E545	- when performed outside hospital add		11.15	

Note:
Vasectomy reversal is an insured benefit only for treatment of significant symptomatology, and requires prior approval. Re-establishing fertility does not constitute significant symptomatology.

MALE GENITAL SURGICAL PROCEDURES

SPERMATIC CORD AND SEMINAL VESICLES

		Asst	Surg	Anae
	SPERMATIC CORD			
# S630	Hydrocele excision - single	5	170.65	5
# S631	Varicocele excision - single	5	170.65	5

Note:
S630 when done with hernia repair use E727.

	SEMINAL VESICLES			
# Z711	Incision of abscess		120.80	5
# S636	Vesiculectomy	5	552.30	5

MALE GENITAL SURGICAL PROCEDURES

PROSTATE

		Asst	Surg	Anae
PREAMBLE				
A transurethral resection followed within 10 days by a bilateral orchidectomy because of carcinoma of the prostate should be claimed in accordance with paragraph (3) of the Surgical Preamble (SP3).				
INCISION				
# Z712	Biopsy, needle		77.70	5
# Z713	- with drainage abscess	5	92.10	5
# S644	Biopsy, perineal, open operation	5	215.80	5
Removal of calculus (with or without biopsy)				
# S642	Perineal	5	437.20	5
# S643	Retropubic	5	437.20	5
EXCISION				
Prostatectomy				
# S645	Perineal	6	574.60	6
# S646	Perineal with vesiculectomy	8	875.00	11
	Suprapubic - with or without removal of bladder stones			
# S647	- one stage	5	600.75	6
# S648	- two stages - 1st stage	5	280.50	6
# S649	- two stages - 2nd stage	5	339.15	6
	Retropubic - with or without removal of bladder stones			
# S650	- simple	5	600.75	6
# S651	- radical	5	1008.35	6
	Note: Prostatectomy not to include investigative cystoscopy and may include vasectomy.			
# S652	Staging pelvic lymphadenectomy for prostatic cancer	7	431.20	7
# S653	Laparoscopic radical prostatectomy	8	1411.70	8
BRACHYTHERAPY				
# S640	Stereotactic prostate brachytherapy	5	627.15	6
	Note: Stereotactic prostate brachytherapy includes the following: **1.** pre-operative prostate volume study - dose planning, assessment and identification of sites for seed implantation; and **2.** operative procedure (implantation of radioactive seeds into the prostate and includes intraoperative imaging (e.g. ultrasound)).			
ENDOSCOPY				
Transurethral resection of prostate				
# S655	- and may include cystoscopy, meatotomy, dilatation of stricture, internal urethrotomy or vasectomy		450.60	6
# S654	- for residual or regrowth of tissue within one year of previous prostatectomy by same surgeon		411.20	6
# S656	Transurethral drainage of abscess		85.30	5

MALE GENITAL SURGICAL PROCEDURES

NOT ALLOCATED

FEMALE GENITAL SURGICAL PROCEDURES

PREAMBLE

Asst Surg Anae

1. In composite operations such as anterior and posterior repair and D&C or anterior and posterior repair and cauterization of cervix and biopsy, the fee shall be that of the major procedure(s).

2. No fee may be claimed for a D&C if:

   a. it is carried out prior to hysterectomy or ectopic pregnancy;

   or

   b. it is carried out routinely prior to tubal occlusion.

3. When operative procedures Z585 - hysteroscopy with embryo transfer and Z718 - laparoscopy for oocyte retrieval are carried out for In Vitro Fertilization, physicians may obtain from their Ministry of Health and Long-Term Care Medical Consultant the current ministry policy regarding conditions approved for coverage under the Plan.

4. When the laparoscope is used as a means of entrance to perform an intra-abdominal procedure, no extra fee for the laparoscopy may be claimed.

5. When a diagnostic laparoscopy is performed prior to laparotomy, the initial procedure should be claimed as E860.

# E857	- a D&C may be claimed at 85% when pregnancy termination (S752, S756, S785) is carried out at tubal occlusion. If a D&C is indicated for abnormal uterine bleeding (S754) independent of the tubal occlusion procedure or diagnostic laparoscopy	add	46.00
# E858	- when operative procedures are carried out for infertility, the fee shall be that of the major procedure. When additional procedure(s) are required, e.g. uterine suspension, oophorocystectomy or myomectomy, may be claimed for each additional procedure	add	70.20
# E854	- ureterolysis - unilateral - payable in conjunction with major gynaecological operative procedure except S743 or S746 and must include surgical definition of pararectal and paravesical spaces, identification of uterine artery and vein, and mobilization of the pelvic ureter from common iliac vessels to ureterovesical junction	add	108.60

FEMALE GENITAL SURGICAL PROCEDURES

VULVA AND INTROITUS

			Asst	Surg	Anae
	INCISION				
# S700	Hymenotomy			50.90	5
	Abscess of vulva, Bartholin or Skene's gland - incision and drainage				
Z714	- local anaesthetic			17.30	
E542	- when performed outside hospital	add		11.15	
# Z715	- general anaesthetic		5	50.90	5
# Z716	Marsupialization of Bartholin's cyst or abscess		5	71.90	5
# Z717	Perineotomy			17.30	
	EXCISION				
	Biopsy(ies) - when sole procedure				
Z477	- local anaesthetic			17.30	
E542	- when performed outside hospital	add		11.15	
# Z475	- general anaesthetic		5	50.90	5
# S707	Hymenectomy (with or without perineotomy)			71.90	5
# S706	Cyst of Bartholin's gland		5	112.00	5
	Condylomata - single or multiple				
	Chemical and/or cryosurgery				
Z733	- one or more			10.55	
	Surgical excision or electrodesiccation or CO_2 laser				
Z736	- local anaesthetic			26.85	
# Z769	- general anaesthetic			115.10	5
	Vulvectomy				
# S703	- simple		5	257.05	5
	- radical				
# S704	- without gland dissection		6	431.45	6
	REPAIR				
# S708	Non-obstetrical injury to vulva and/or vagina, and/or perineum (see General Preamble GP12)			I.C	I.C
# S701	Repair of infibulation - resulting from female genital mutilation			82.15	5

FEMALE GENITAL SURGICAL PROCEDURES

VAGINA

		Asst	Surg	Anae
	ENDOSCOPY			
Z478	Vaginoscopy (premenarchal) with or without medication		50.90	5
	Note: Culdoscopy - see Z552 - Abdomen, Peritoneum and Omentum - Digestive System			
	INCISION			
# S712	Culdotomy, drainage or needle puncture		71.90	5
Z728	Incision and drainage of cyst, abscess or haematoma		50.90	5
	EXCISION			
	Biopsy(ies) - when sole procedure			
Z722	- local anaesthetic		17.30	
# Z723	- general anaesthetic		50.90	5
# S715	Excision of cyst(s), or benign tumour(s)	5	123.70	5
# S742	Colpectomy - e.g. for carcinoma	5	349.00	6
# S702	Excision of congenital vaginal septum	5	123.70	5

FEMALE GENITAL SURGICAL PROCEDURES

VAGINA

		Asst	Surg	Anae
	REPAIR			
# S716	Anterior or posterior repair	5	164.00	5
	Anterior and posterior			
# S717	- repair	5	257.05	5
# S718	- repair of enterocoele and/or vault prolapse	5	349.00	5
	Posterior repair and repair of			
# S719	- enterocoele and/or vault prolapse	5	307.80	5
# S723	- anal sphincter	5	272.40	5
	Anterior repair			
# S720	- with or without posterior repair and repair of uterine prolapse (Fothergill or Watkin's interposition)	5	349.00	5
# S721	Anterior, posterior repair with excision of cervical stump	5	349.00	6
	Post hysterectomy vault prolapse			
# S722	- repair by vaginal approach, may include enterocoele and/or anterior and posterior repair	5	349.00	6
# S812	- repeat - repair by vaginal approach, may include enterocoele and/or anterior and posterior repair	5	453.70	6
	Abdominal approach to vaginal vault prolapse			
# S760	- vaginal sacropexy	5	349.00	6
# S813	- repeat - vaginal sacropexy	5	453.70	6
# S808	Laparoscopic vaginal sacropexy	6	436.25	6
# S761	Combined abdominal/vaginal approach for vaginal vault prolapse	7	431.45	7
# S806	Laparoscopic combined abdominal/vaginal approach for vaginal vault prolapse	6	539.35	6
# S724	Perineorrhaphy (not to be claimed with delivery or other vaginal surgery procedures)	5	122.75	5
# S725	Colpocleisis (LeFort or modification)	5	257.05	5
# S726	Construction of artificial vagina (see General Preamble GP12)	5	I.C	6
	Closure of fistula			
# S523	Vesicovaginal - single surgeon	5	435.20	6
	Vesicovaginal - two surgeons			
# S734	- vaginal surgeon	5	297.25	6
# S711	- abdominal surgeon		297.25	
	Note: S711 - see also S524 - Bladder Procedures.			
S231	Rectovaginal (any repair)	5	338.55	6
# S729	Ureterovaginal	6	560.95	6
# S709	Urethrovaginal	5	374.85	5

FEMALE GENITAL SURGICAL PROCEDURES

VAGINA

		Asst	Surg	Anae
	RETROPUBIC URETHROPEXY			
# S549	Primary procedure	5	301.35	6
# S546	- repeat procedure for failed retropubic or vaginal surgery for stress incontinence	5	353.90	6
# S805	Laparoscopic retropubic urethropexy	6	376.65	6
# S807	Laparoscopic repeat retropubic urethropexy	8	442.30	8
	Combined abdominal-vaginal procedure for stress incontinence (sling procedure)			
	Primary approach			
# S728	One surgeon	7	319.80	7
# E862	- when performed laparoscopically add 25%			
	Two surgeons			
# S730	- vaginal surgeon	7	181.20	7
# E863	- when performed laparoscopically add 10%			
# S740	- abdominal surgeon		250.20	
# E862	- when performed laparoscopically add 25%			
	Following previous failed procedure			
# S731	One surgeon	7	431.45	7
# E862	- when performed laparoscopically add 25%			
	Two surgeons			
# S732	- vaginal surgeon	7	257.05	7
# E863	- when performed laparoscopically add 10%			
# S733	- abdominal surgeon		349.00	
# E862	- when performed laparoscopically add 25%			
	Following two or more failed procedures			
# S748	One surgeon	7	671.20	7
# E862	- when performed laparoscopically add 25%			
	Two surgeons			
# S749	- vaginal surgeon	7	431.45	7
# E863	- when performed laparoscopically add 10%			
# S751	- abdominal surgeon		479.45	
# E862	- when performed laparoscopically add 25%			
# S811	Rectus abdominus myocutaneous neovaginostomy - includes harvest of longitudinal, vertical or transverse rectus abdominus flap(s), formation of vaginal pouch and insertion of vaginal mold	8	829.40	8

FEMALE GENITAL SURGICAL PROCEDURES

VAGINA

Asst | Surg | Anae

MANIPULATION

Examination and/or dilatation (may include insertion and/or removal of IUD)

Z735 - general anaesthetic - as sole procedure 50.90 5

UVC Removal of IUD without GA ..... visit fee

FEMALE GENITAL SURGICAL PROCEDURES

CERVIX UTERI

		Asst	Surg	Anae
	ENDOSCOPY			
Z731	Initial investigation of abnormal cytology of vulva and/or vagina or cervix under colposcopic technique (to include biopsies and curetting)		50.90	
Z730	Follow up colposcopy		25.50	
	Note: A screening colposcopy is included in the assessment.			
	CAUTERIZATION			
UVC	Chemical		visit fee	
Z732	Cryotherapy		17.30	
Z724	Electro.		8.55	
# Z725	Dilatation and cauterization under general anaesthesia		50.90	5
	CONIZATION			
# Z766	Loop Electrosurgical Excision Procedure (LEEP)		78.00	
# S744	Cervix - cone biopsy - any technique, with or without D&C	5	173.15	5
Z729	Cryoconization, electroconization or CO_2 laser therapy with or without curettage for premalignant lesion (dysplasia or carcinoma in situ), out-patient procedure		38.35	
	EXCISION			
Z720	Biopsy - with or without fulguration		17.30	5
# S765	Amputation of cervix	5	173.55	5
	Cervical stump			
# S766	- abdominal	6	257.05	6
# S767	- vaginal	5	257.05	5
	Note: Excision of cervical polyp(s) under general anaesthesia, use Z720.			

FEMALE GENITAL SURGICAL PROCEDURES

CORPUS UTERI

		Asst	Surg	Anae
	REPAIR			
# S774	Repair of incompetent cervix - not associated with pregnancy	5	142.50	5
	ENDOSCOPY			
	Hysteroscopy			
# Z582	- diagnostic		105.40	5
# Z583	- with uterine biopsy and/or D&C		131.40	5
# Z585	- with cannulization of tube(s), lysis of intrauterine adhesions or embryo transfer		131.40	5
	INCISION OR EXCISION			
# E861	- paracervical block - payable in addition to endometrial sampling, ablation or curettage by same physician in an office - unilateral or bilateral add		9.00	
Z770	Endometrial sampling		29.05	
E542	- when performed outside hospital add		11.15	
# S772	Endometrial ablation by any method		218.65	5
# S773	Endometrial ablation by any method, within one year of previous ablation by same surgeon		153.05	5

Note:
Hysteroscopy (Z582, Z583) is not eligible for payment when rendered with endometrial ablation (S772, S773).

	Abortion			
UVC	- spontaneous, complete		visit fee	
# S768	- spontaneous, incomplete - including D&C		93.00	5
# S752	- induced - curettage, intra-amniotic injection (complete)		112.40	5
# S785	- induced - intra-amniotic injection (incomplete) followed by curettage, or by any technique after 16 weeks of gestation (only if length of gestation is confirmed by ultrasound)		189.85	5
# S756	- missed abortion, or evacuation of molar pregnancy		112.40	5
# S770	- hysterotomy	6	245.40	6
# S783	- hysterotomy with tubal interruption	6	257.05	6
# S754	Diagnostic curettage (with or without cauterization, biopsy of cervix removal of polyps, Rubin's test or hysterosalpingography)		92.30	5
# S753	Intracavitary application of radium or sealed sources including D&C carried out at same time as application (to include consultation fee) - first application		184.10	5
# S755	- repeat application		92.10	5
# S764	Myomectomy	6	349.00	6
# S810	Laparoscopic vaginal hysterectomy	8	536.40	8

FEMALE GENITAL SURGICAL PROCEDURES

CORPUS UTERI

		Asst	Surg	Anae
	INCISION OR EXCISION			
	Hysterectomy - with or without adnexa			
# S757	- total or subtotal - abdominal or vaginal	6	429.10	6
# S758	- with anterior and posterior vaginal repair to include enterocoele and/or vault prolapse as required	6	616.60	6
# S759	- with anterior or posterior vaginal repair including enterocoele and/or vault prolapse	6	523.55	6
# S710	- with omentectomy for malignancy	6	680.65	6
# S763	- radical (Wertheim or Schauta) - includes node dissection	8	893.55	8
# S762	- radical trachelectomy - excluding node dissection	8	801.10	8

Note:
S757, S758, S759, S710, S763, S762 are total fees. The following codes are not allowed in addition: S722, S760, S812, S813, S738, S741, S745-S747, S780-S782.

# S776	Staging pelvic node lymphadenectomy for carcinoma (laparoscopic or open)	6	431.20	6
# S781	Para-aortic lymph node dissection (laparoscopic or open) (not to be claimed with Z578 and/or S776)	6	431.20	6
	REPAIR			
	Uterine suspension			
# S771	- any technique - sole procedure	6	248.30	6
# E859	- uterine suspension in conjunction with major procedure	add	47.90	
	Hysteroplasty			
# S779	- excision of septum	6	349.00	6
# S775	- unification of double uterus (Strassman)	5	431.45	5
# S777	- uterine inversion, operative	5	349.00	6
# S778	Presacral neurectomy (with or without ovarian neurectomy)	6	349.00	6

FEMALE GENITAL SURGICAL PROCEDURES

FALLOPIAN TUBE

			Asst	Surg	Anae
	EXCISION, SUTURE OR REPAIR				
	Ectopic pregnancy				
# S784	- management by any surgical technique		6	306.85	6
# E852	- with tuboplasty	add		47.90	
# E860	- diagnostic laparoscopy prior to laparotomy	add		71.90	
# S738	Salpingectomy and salpingo-oophorectomy (uni- or bilateral)		6	306.85	6
# S741	Tubal occlusion/interruption/removal by any method or approach for the purpose of sterilization		6	155.70	6
	Tubal plastic operation with/without operating microscope (uni- or bilateral)				
# S735	- fimbriolysis		6	306.85	6
# S736	- salpingostomy		6	359.55	6
# S739	- fimbriolysis and salpingostomy		6	407.45	6
	Repair of extensive unilateral or bilateral tubal and peritubal disease				
	For infertility, pelvic inflammatory disease or endometriosis using operating microscope with or without laser treatment and ureterolysis				
# S743	- laparotomy		8	616.60	8
# S746	- laparoscopic technique		8	770.75	8

Note:

1. S743, Z737 or E854 claimed for same patient same day as S746 by any surgeon is an insured service payable at nil.
2. Reconstruction or repair for infertility following previous sterilization is not an insured service.

	Laparoscopy				
# Z552	- diagnostic		5	131.45	6
# Z553	- with biopsy and/or lysis of adhesions and/or removal of foreign body and/or cautery of endometrial implants		5	173.25	6
# E855	- with dye injection	add		25.85	
# E856	- with endometrial	add		25.85	
# E857	- with D&C	add		46.00	
# Z718	Laparoscopy for oocyte retrieval		5	174.50	6
# Z737	Laser treatment of extensive pelvic disease		5	215.80	6

ENDOCRINE SURGICAL PROCEDURES

THYROID GLAND

		Asst	Surg	Anae
	INCISION			
Z726	Aspiration, thyroid cyst		28.60	
# Z727	Percutaneous silicone core needle biopsy		57.50	6
Z771	Aspiration biopsy, thyroid gland or nodule fine needle method		28.60	
# S786	Abscess		82.25	5
	EXCISION			
	Biopsy			
# S787	- surgical	5	213.15	6
	Thyroidectomy			
# S788	- total	6	615.90	8
# S789	- subtotal	6	484.15	7
# S790	- hemi	6	369.80	7
# E880	- parathyroid(s) re-implantation add		184.60	
# E881	- if requiring splitting of sternum add		82.25	
# S791	Excision of solitary nodule	6	303.80	6

ENDOCRINE SURGICAL PROCEDURES

PARATHYROID, THYMUS AND ADRENAL GLANDS

		Asst	Surg	Anae
	EXCISION			
# S795	Exploration and/or removal, parathyroids or parathyroid tumour	6	605.45	8
# S796	- if requiring splitting of sternum	10	687.60	13
# E880	- parathyroid(s) re-implantation ... add		184.60	
# E885	- transcervical thymectomy performed in association with parathyroidectomy ... add		106.00	
# S792	Re-exploration of neck for hyperparathyroidism	6	687.60	8
# E882	- with hemi thyroidectomy ... add		177.40	
# E883	- with subtotal thyroidectomy ... add		266.60	
# E884	- with total thyroidectomy ... add		374.00	
# S797	Thymectomy	10	615.10	13
	Adrenalectomy or exploration			
# S798	- unilateral	10	430.85	10
# S799	- bilateral, with or without oophorectomy	10	668.45	11
	Adrenalectomy			
# S800	- unilateral for pheochromocytoma	10	581.20	13
# E793	- laparoscopic or laparoscopic assisted, to S798, S799 or S800 ... add 25%			

Note:
When an adrenalectomy is performed in conjunction with a nephrectomy, and is incidental to the removal of the kidney, there should be no additional claim for the adrenalectomy.

# Z772	Thymus transplant		81.45	5

NEUROLOGICAL SURGICAL PROCEDURES

CRANIAL

		Asst	Surg	Anae
	CRANIAL NERVES			
# N258	Percutaneous coagulation or glyceral injection of gasserian (trigeminal) ganglion or root - unilateral	nil	409.85	11
# N259	V - Decompression or rhizotomy (partial or complete) trigeminal nerve	11	481.90	11
# N265	VII - Differential section facial nerve for hemi-facial spasm (extracranial approach)	6	348.30	6
# N266	Anastomosis hypoglossal or accessory to facial nerve	6	563.50	6
# N267	Occipital and/or suboccipital craniectomy for compression, decompression or section of cranial nerves	11	963.00	11
# E901	- with operating microscope, to N266, N267 add		215.35	
# N269	XI - Division of nerves to sternomastoid in neck	6	292.25	6
# Z826	Inferior dental neurectomy	5	184.00	5
# Z827	Infraorbital or supraorbital neurectomy	5	158.45	5
	CAROTID AND VERTEBRAL ARTERIES			
# N220	Carotid endarterectomy (with or without bypass and/or patch graft)	10	764.20	10
# N223	Vertebral endarterectomy	10	798.80	10
# Z815	Temporal artery - biopsy, ligation or cryosurgery		107.20	5
# Z808	Progressive carotid occlusion by Selverstone clamp	10	317.85	10
# Z807	Removal of Selverstone clamp	10	266.60	10
# E381	- intra-operative diagnostic or physiological neuro monitoring, to N220, Z808 add		179.30	
	CSF SHUNTING PROCEDURES			
# N230	CSF shunting procedures - all types	11	474.45	11
	Revision of CSF shunt			
# N245	- operative - all types	7	281.70	7
# Z801	- non-operative		40.80	
	Conversion of shunt (e.g. ventriculoperitoneal to ventriculoatrial)			
# N174	- includes removal of existing shunt	7	420.30	7
# N246	Removal of shunt - any type	7	184.00	7
# Z809	Insertion of CSF reservoir (Ommaya) including burr holes	11	241.00	11
# N249	Third ventriculostomy	11	655.60	11
# Z821	Injection of diagnostic or therapeutic agent into shunt apparatus		53.10	

NEUROLOGICAL SURGICAL PROCEDURES

CRANIAL

			Asst	Surg	Anae
	SKULL				
	Repair of skull defect				
# N161	Acrylic or metal cranioplasty		11	563.50	11
# N201	Rib graft cranioplasty (defect less than 7.5 cm)		15	855.80	15
# N202	Replacement of bone flap		11	481.90	11
# N203	Skull tumour, excision		11	373.80	11
	Craniosynostosis, linear craniectomy				
# N206	- one suture		11	430.75	11
# N207	- multiple sutures		15	563.50	15
	Morcellation procedure				
# N162	- one suture		11	430.75	11
# N163	- multiple sutures		15	614.70	15
	Lateral canthal advancement				
	Unilateral				
# N164	- one surgeon		15	696.35	15
# N165	- two surgeons, major portion		15	430.75	15
# N166	- two surgeons, lesser portion			345.35	
	Bilateral				
# N167	- one surgeon		15	952.55	15
# N168	- two surgeons, major portion		15	614.70	15
# N169	- two surgeons, lesser portion			461.10	
	Craniotomy				
# N208	- for craniofacial repair		15	918.15	15
# E922	- with repair of frontonasal encephalocele	add		215.35	
	ORBIT				
	Craniotomy				
# N211	- plus removal of orbital tumour		15	1116.60	15
# N212	- plus orbital decompression (roof of orbit with or without lateral wall)		15	1045.45	15
# N213	- for decompression of optic nerve(s)		15	1116.60	15
# E901	- with operating microscope, to N211, N213	add		215.35	

NEUROLOGICAL SURGICAL PROCEDURES

PERIPHERAL NERVES

		Asst	Surg	Anae
# E906	- to basic fee for neurolysis, tumour excision, nerve suture or graft when using operating microscope ..... add 40%			
# E381	- intra-operative, diagnostic or physiological neuro monitoring ..... add		179.30	
# E925	- to basic fee for a repeat peripheral nerve procedure, (e.g. repair, transposition, graft or tumour excision) when repair delayed for more than 4 weeks ..... add 30%			

Exploration, decompression, division, excision, biopsy, neurolysis and/or transposition

# N188	- minor nerve - including digital, cutaneous or lateral femoral cutaneous nerve	5	153.70	5
# N285	- major nerve - excluding carpal tunnel or ulnar nerve at elbow	5	256.15	5

Note:
N188 or N285 when performed through the same incision as flexor tendon repairs R585 or E581 is an insured service payable at nil.

# N282	Brachial plexus (excluding thoracic outlet syndrome or cervical rib)	6	593.85	6
# N177	Sciatic nerve in buttock	6	430.75	6
# N286	Tumour or neuroma - major nerve	5	317.85	5

Nerve suture

# N289	- minor - (sensory/cutaneous nerve)	5	184.00	5
# N287	- major - (mixed sensory and motor nerve, or pure motor nerve)	5	430.75	5

Nerve graft

# N183	- minor - (sensory/cutaneous nerve)	5	307.40	5
# N288	- major - (mixed sensory and motor nerve, or pure motor nerve)	5	614.70	5
# E899	- for each additional cable, to N288 ..... add		102.45	

Note:
Nerve graft fees include harvesting of the nerve(s) required for grafting.

# Z816	Implantation of electrode for peripheral nerve stimulation	5	241.00	5
# Z823	Implantation or revision of stimulation pack or leads, (peripheral nerve, brain)	6	307.40	8
# N290	Carpal tunnel release	5	156.50	5
# N190	Exploration and/or decompression and/or neurolysis of ulnar nerve (elbow)	5	215.35	5
# N189	Ulnar nerve transposition at elbow - may include exploration, decompression and/or neurolysis	5	279.25	5
# N283	Decompression, exploration for thoracic outlet syndrome including excision of cervical and/or first rib and to include scalenotomy	6	389.05	6
# N295	Excision of Morton's or subcutaneous neuroma, glomus or small cutaneous nerve tumour	5	109.95	5
# E911	- implantation of neuroma into bone or muscle, to N286, N295 ..... add 40%			

NEUROLOGICAL SURGICAL PROCEDURES

NOT ALLOCATED

OCULAR AND AURAL SURGICAL PROCEDURES

EYEBALL

		Asst	Surg	Anae
	EXAMINATION			
# Z850	- when sole procedure or with unlisted minor procedures with general anaesthesia		95.15	5
E982	- when service is rendered to newborn, infant or child (ages 0 to 15 inclusive), to Z850 add 30%			
	EXCISION			
# E108	Enucleation, donor eye, post-mortem (one or both)		131.25	
	REPAIR			
# E104	Removal of intraocular foreign body	5	415.85	6
# E105	Non-magnetic - posterior segment	5	424.35	6
	Penetrating wound			
# E106	- with prolapse of intraocular tissue	5	308.30	6
# E107	- without prolapse of intraocular tissue	5	246.55	6

OCULAR AND AURAL SURGICAL PROCEDURES

CORNEA

			Asst	Surg	Anae
	INCISION				
# Z851	Paracentesis			52.40	5
	Removal embedded foreign body				
	- local anaesthetic				
Z847	- one foreign body			26.60	
Z848	- two foreign bodies			38.00	
Z845	- three or more foreign bodies (see General Preamble GP12)			I.C	
# Z852	- general anaesthetic			74.20	5
	Chelation of band keratopathy with EDTA				
Z849	- local anaesthetic			26.60	
# Z863	- general anaesthetic			74.20	5
# E128	Anterior chamber - open evacuation of clot		5	369.25	6
	EXCISION				
	Pterygium				
# E206	- simple (unilateral)			138.90	5
# E205	- with partial keratectomy		5	308.30	5
# E207	- with lamellar graft		5	453.00	8
# E937	- with autogenous conjunctival transplant	add		80.90	
# E948	- with mucous membrane graft	add		113.20	
# E117	Keratectomy or relaxing incisions post penetrating keratoplasty or post traumatic corneal scar (non cosmetic)		5	308.30	5
	Excision of dermoid				
# E118	- with partial keratectomy			308.30	5
# E119	- with lamellar graft		5	453.00	8
	Ulcer cautery				
	Including laser and/or electrocautery, epithelial debridement, cryotherapy, corneal biopsy and/or corneal puncture				
Z871	- local anaesthetic			26.60	
# Z853	- general anaesthetic			74.20	5
	REPLACEMENT				
	Corneal transplant				
# E121	- penetrating		5	575.85	8
# E951	- with artificial prosthesis	add		52.40	
# E122	- lamellar		5	453.00	8
# E123	Division of iris to cornea			161.75	5

OCULAR AND AURAL SURGICAL PROCEDURES

SCLERA, IRIS AND CILIARY BODY

		Asst	Surg	Anae
	SCLERA			
# E127	Sclerotomy, posterior		166.45	5
	IRIS AND CILIARY BODY			
# E131	Laser iridotomy	5	161.75	5
# E134	Laser angle surgery		205.55	5
# E130	Iridectomy - surgical - when sole procedure	5	308.30	5
# E132	Glaucoma filtering procedures	5	370.20	6
# E983	- following previous glaucoma filtering procedure, to E132 ... add 25%			
# E136	- with intraocular implant of seton, to E132 ... add 15%			
# E133	Extraocular glaucoma procedures	5	182.75	5
# E135	Ciliary body re-attachment	5	505.45	8

OCULAR AND AURAL SURGICAL PROCEDURES

CRYSTALLINE LENS

		Asst	Surg	Anae
	INCISION			
# E137	Needling (discission) - primary or subsequent	5	161.75	5
# E139	Capsulotomy	5	161.75	5
	EXCISION			
	Cataract			
	To include retrobulbar injection when administered by surgeon			
# E140	- all types of, by any procedure		413.60	6
# E141	- dislocated lens extraction	5	505.45	6
# E950	- insertion of intraocular lens, add		102.75	
# E143	Excision of secondary membrane with corneal section following cataract extraction	5	262.70	6
# E138	Fixation of intraocular lens (McCannell suture procedure)	5	267.35	6
# E144	Removal of intraocular lens	5	314.05	6
# E145	Repositioning surgical of dislocated intraocular lens		161.75	5
# E146	Insertion of secondary intraocular lens	5	308.30	8

OCULAR AND AURAL SURGICAL PROCEDURES

VITREOUS

			Asst	Surg	Anae
	Anterior vitrectomy				
# E940	- when done in conjunction with another intraocular procedure	add		89.45	
# E148	Vitrectomy by infusion suction cutter technique		5	699.50	8
# E938	- with transscleral retinal suturing	add		213.20	
# E149	Vitreous injection or aspiration, posterior with needle for culture and/or injection of medication		5	181.75	5
# E142	Preretinal membrane peeling or segmentation to include posterior vitrectomy and coagulation		5	782.35	8
	Vitreous exchange (air, gas or artificial vitreous substance)				
# E936	- to vitrectomy	add		60.90	

			Asst	Surg	Anae
	RETINA				
# E151	Re-attachment of retina and choroid by diathermy, photocoagulation or cryopexy as an initial procedure		6	282.65	6
# E152	Scleral resection or buckling procedure - with or without diathermy, photo-coagulation or cryopexy, primary or subsequent procedure		6	658.55	6
# E153	Secondary operation following unsuccessful operation or fresh detachment in the same eye by a different surgeon with or without diathermy, photocoagulation or cryopexy		6	761.35	6
# E161	Removal of scleral implant			185.60	5
# E154	Photocoagulation (xenon, argon laser, etc.) - one eye			182.75	6
# E155	Cryopexy - extraocular or sub-conjunctival - one eye			182.75	6
	REPAIR				
	Strabismus procedures				
# E159	- one muscle, one or both eyes		5	315.25	5
# E158	- two muscles, one or both eyes		5	444.25	5
# E162	- three or more muscles, one or both eyes		5	514.05	5
# E949	- for adjustable suture	add		81.85	
# E952	- repeat strabismus procedure	add		123.70	

OCULAR AND AURAL SURGICAL PROCEDURES

ORBIT

		Asst	Surg	Anae
	INCISION			
# E164	Drainage of abscess		197.90	6
	EXCISION			
# E102	Enucleation, with or without primary implant	5	262.70	5
# E103	Evisceration, with or without primary implant	5	262.80	5
# E109	Enucleation/evisceration with insertion of implant and reattachment of extraocular muscles	5	328.40	5
	Note: E102 or E103 are not eligible for payment with E109.			
# E171	Exenteration	5	296.90	6
# E941	- with major plastic repair add		296.90	
# E181	Secondary orbital implant	5	372.05	5
	Tumour or foreign body			
# E166	- anterior route	5	308.30	6
# E167	- posterior exposure	5	514.80	6
# E172	Biopsy (anterior)		161.75	5
# E168	Biopsy (posterior exposure)		308.30	5
# E165	Lateral orbitotomy (Kronlein)	5	424.35	6
	Decompression			
# E169	- two walls	5	494.00	6
# E170	- three walls	5	575.85	6
	RECONSTRUCTION			
	Dermis fat graft			
# E160	- immediately following enucleation		190.30	
# E163	- delayed	5	514.80	6
# E176	Fornix reconstruction		246.55	5
# E177	- with mucous membrane graft		321.60	5
# E937	- with autogenous conjunctival transplant add		80.90	
	Free mucous membrane graft			
# E178	- full thickness		222.65	5
# E179	- split thickness		296.90	5
# E180	Alloplastic volume replacement		411.20	5
	Note: Repair - for E173 and E174 see Skull and Mandible - Musculoskeletal System.			

OCULAR AND AURAL SURGICAL PROCEDURES

EYELIDS

			Asst	Surg	Anae
	INCISION				
	Drainage of abscess				
Z854	- local anaesthetic			40.90	
# Z855	- general anaesthetic			81.85	5
	EXCISION				
	Chalazion				
	Single or multiple				
Z874	- local anaesthetic			40.90	
E542	- when performed outside hospital	add		11.15	
# Z856	- general anaesthetic			81.85	5
	Note:				
	See Appendix D Surface Pathology.				
	Epilation				
Z857	- by hyfrecator, electrolysis			26.60	5
Z858	- by cryopexy			65.70	5
	Note:				
	Verruca, keratosis, etc. - see Skin and Subcutaneous Tissue - Integumentary System also Lid Tumours or Unlisted Plastic Procedures.				
	SUTURE				
# E190	Tarsorrhaphy			111.40	5
# E191	Double adhesion			161.75	5
	REPAIR				
# E192	Ptosis		5	313.15	5
# E193	- repeat or second repair		5	393.00	6
# E194	Distichiasis - unilateral		5	241.70	5
# E195	Trichiasis, repair by tarsal transplantation		5	241.70	5
# E196	Entropion, other than Zeigler puncture		5	262.70	5
# E945	- repeat by second surgeon	add		52.40	
# E948	- with mucous membrane graft	add		113.20	
# E197	Ectropion, other than Zeigler puncture		5	262.70	5
# E945	- repeat by second surgeon	add		52.40	
Z860	Zeigler punctures (for entropion/ectropion)			26.60	5
	Note:				
	With skin graft - see Plastic Surgery Procedures - Integumentary System.				
# E199	Laceration, full thickness			131.25	5
# E198	- including lid margin			262.70	5

OCULAR AND AURAL SURGICAL PROCEDURES

EYELIDS

		Asst	Surg	Anae
# E221	Laceration of eyelid including levator palpebrae superioris with ptosis	5	329.30	5

Blepharoplasty

# E200	- excision of skin, with or without partial excision of the orbicularis oculi muscle - one lid		82.80	5
# E201	- same as E200 plus removal of orbital fat and/or major lid fold reconstruction - one lid	5	205.55	5

Note:
Blepharoplasty is only insured in those circumstances described in the Appendix D - prior approval of the Ministry of Health and Long-Term Care is required.

# E211	Lid lengthening procedure	5	288.35	5
# E953	- with scleral graft	add	80.90	
# E222	Primary closure of full thickness lid defect	5	267.35	5
# E942	- with cantholysis	add	53.20	
# E943	- with releasing rotation flap including cantholysis	add	89.45	
# E223	Tarsoconjunctival flap and skin graft (Hughes)	5	484.35	6
# E224	- second stage		108.45	5
# E225	Lower or upper eyelid bridge flap	5	484.35	6
# E226	- second stage		108.45	5
# E227	Temporal rotation flap	5	514.80	6
# E944	- with free posterior lamellar graft	add	175.15	
# E228	Free tarsal, scleral or cartilage graft with local skin mobilization	6	535.80	8
# E229	Free composite eyelid graft	6	535.80	8
# E230	Medial canthoplasty (skin and muscle)	5	257.90	5

Medial canthal tendon

# E231	- tendon repair only	5	267.35	5
# E232	- fixation to bone	5	412.05	6
# E233	- when done in conjunction with another procedure	add	153.25	

Lateral canthal surgery

# E234	- canthotomy (not to be claimed with E140, E141)		51.45	5
# E977	- if excision is performed in hospital for tumour free margin with frozen section, to excision or repair fees	add 25%		

Note:
E977 is payable only in addition to codes E222, E223, E225, E226, E227, E228, E229 or E300.

# E235	Cantholysis - when primary procedure		107.50	5
# E236	Lateral canthopexy		203.70	5
# E930	- when done in conjunction with another procedure	add	102.35	
UVC	Removal of foreign body		visit fee	

OCULAR AND AURAL SURGICAL PROCEDURES

CONJUNCTIVA

			Asst	Surg	Anae
	EXCISION				
# E208	Peritomy (C nderson conjunctival flap)			111.40	5
Z861	Biopsy			26.60	5
	REPAIR				
# E210	Excision of conjunctival lesion			80.90	5
# E948	- with mucous membrane graft	add		113.20	
E937	- with autogenous conjunctival transplant	add		80.90	

OCULAR AND AURAL SURGICAL PROCEDURES

LACRIMAL TRACT

		Asst	Surg	Anae
	INCISION			
# Z862	Dacryocystotomy - general anaesthetic		52.40	5
# Z917	Three "Snip" punctum procedure - per punctum - maximum 4 per patient ... each		65.70	5
	EXCISION			
# E215	Dacryocystectomy	5	262.70	5
	REPAIR			
	Lacerated canaliculus			
# E216	- immediate repair	5	212.15	5
# E217	- delayed repair	5	411.20	5
# E218	Dacryocystorhinostomy	5	424.35	5
# E939	- repeat procedure by second surgeon ... add		87.55	
# E954	- with lacrimal bypass procedure (e.g. Lester Jones) or canalicular reconstruction ... add		80.90	
	Lacrimal bypass procedure (e.g. Lester Jones)			
# E219	- when sole procedure (both stages)		181.75	5
	MANIPULATION			
Z901	Irrigation of nasolacrimal system - unilateral or bilateral		21.00	
	Probing and dilation of duct, initial or repeat			
	Local anaesthetic			
Z902	- unilateral		21.00	
	General anaesthetic			
# Z864	- unilateral or bilateral		80.90	5
# Z865	- with insertion of inlying tube or filament		160.85	5
Z918	Re-insertion of Lester Jones tube		52.40	

OCULAR AND AURAL SURGICAL PROCEDURES

EXTERNAL EAR

		Assf	Surg	Anae

PREAMBLE

When debridement of ears under microscopy is carried out for access purposes only, no claim should be made for the debridement.

ENDOSCOPY

Removal of foreign body

Z915	- simple	10.55		
Z866	- complicated, general anaesthetic	50.90	5	
# E302	- requiring post auricular or endaural incisions	202.35	5	
# E303	- from middle ear space	202.35	5	

Note:
Z915 claimed solely for removal of cerumen is payable at nil.

Removal of drainage tube(s)

# Z906	- general anaesthetic	35.50	5	

INCISION

Z909	Biopsy, ear canal	25.85		
# Z846	- general anaesthetic (if sole procedure performed)	50.90	5	

Incision and drainage of extensive haematoma of pinna with packing of ear and external compression dressing

# E317	- general anaesthetic	139.95	5	
# E318	- local anaesthetic	92.40		
# E305	Limited incision for perichondritis, removal of cartilage and drainage	155.30	5	
# E306	Radical surgery for perichondritis	291.50	5	

EXCISION

Local excision, polyp

Z904	- office	25.85		
# Z905	- hospital	50.90	5	

Resection of pinna

# E300	- with primary closure	172.65	5	
# E977	- if excision is performed in hospital for tumour free margin with frozen section, to excision or repair fees, to E300	add 25%		
# E301	- with local flap	247.35	5	

Exostosis

# E311	- simple endomeatal surgery and removal and drilling out of exostosis	197.45	5	
# E312	- with multiple removal with necessary grafting	247.35	5	
# E313	- post auricular approach	297.25	5	
# Z903	Pre-auricular sinus	33.60		
# E309	- general anaesthetic	208.05	5	

OCULAR AND AURAL SURGICAL PROCEDURES

EXTERNAL EAR

		Asst	Surg	Anae
	REPAIR			
	Congenital defects			
	External			
# E307	- minor	5	219.60	5
# E308	- major	5	345.15	5
# E310	Otoplasty for correction of outstanding ears - unilateral	5	233.00	5
# E304	Reconstruction of total ear with cartilage graft (e.g. Brent Technique), first stage	5	619.35	9

Note:

1. E304, E307, E308 - Descriptive details of procedure (e.g. operative report) should be submitted with claims for professional assessment (see Surgical Preamble, paragraph 18).
2. E310 - for patients 18 years of age or older, please see Appendix D, Sub-Surface Pathology.

# E314	Meatoplasty or canalplasty for congenital malformation	5	297.25	5
# E955	- with grafting of canal, add		202.35	1
# E956	- with tympanoplasty and/or ossiculoplasty, and/or mastoidectomy, add		399.90	2

OCULAR AND AURAL SURGICAL PROCEDURES

MIDDLE EAR

			Asst	Surg	Anae
	INTRODUCTION				
	Under microscopy, debridement of mastoid cavities, and/or ears with significant external or middle ear pathology and/or repair of small perforation but not for removal of cerumen.				
Z907	- unilateral or bilateral			26.85	
# Z908	- under general anaesthetic - when sole ear procedure performed			50.90	5
	Note: Debridement not performed under microscopy (e.g. if performed using loupes or magnifying headlights) or in the absence of significant external or middle ear pathology, or for removal of cerumen must be claimed under G420.				
	INCISION				
# Z912	Myringotomy, to include aspiration when indicated - unilateral			42.15	5
# Z914	- with insertion of ventilation tube using operating microscope - unilateral			78.60	5
	EXCISION				
	Mastoidectomy				
# E320	Cortical mastoidectomy		5	345.15	6
# E322	Modified or radical mastoidectomy		5	514.70	7
# E315	Revision mastoidectomy with revision of middle ear		5	553.20	7
# E946	- with mastoid cavity obliteration (E320, E322 or E315)	add		106.45	
# E959	- with meatoplasty and/or canalplasty	add		106.45	
# E960	- with ossiculoplasty (E320, E322 or E315)	add		85.30	
	REPAIR				
# E323	Myringoplasty			209.05	5
	Tympanoplasty				
# E336	Type 1 (myringoplasty with exploration of middle ear)			345.15	7
# E337	- with ossiculoplasty			468.85	7
# E957	- with mastoidectomy	add		138.05	
# E959	- with meatoplasty and/or canalplasty	add		106.45	
# E333	Ossiculoplasty		5	406.55	7
# E325	Facial nerve decompression		5	642.45	9
# E326	Facial nerve grafting (to include decompression)		5	987.65	9
# E327	Closure of mastoid fistula		5	252.15	5
# E328	Tympanotomy			236.80	5
# E981	- with removal of middle ear tumour	add		92.10	2
# E329	Tympanic neurectomy			370.10	6
# E316	Tympanotomy with fistula repair			395.05	6
# E350	Donor homograft - tympanic membrane, malleus and incus in continuity - unilateral			136.15	

OCULAR AND AURAL SURGICAL PROCEDURES

INNER EAR

		Asst	Surg	Anae
	INCISION			
# E332	Labyrinthotomy or labyrinthectomy (including Fick procedure)		548.45	7
	REPAIR			
# E335	Stapedectomy with prosthesis		548.45	6
# E338	Singular nerve section	5	661.55	9
# E339	Endolymphatic shunt or sac decompression	5	661.55	9
# E345	Temporal bone resection	10	1235.00	15
	Permanent Cochlear Prosthesis Insertion			
# E340	Extra-cochlear (round window, middle ear)	7	553.20	9
# E341	Intra-cochlear	7	737.30	9
	Bone Conduction Hearing Aid Insertion			
# E346	- implantable, including necessary mastoidectomy	5	345.15	6

OCULAR AND AURAL SURGICAL PROCEDURES

NOT ALLOCATED

SPINAL SURGICAL PROCEDURES

ANTERIOR SPINAL ARTHRODESIS FOLLOWING DECOMPRESSION

			Asst	Surg	Anae
	Cervical - without instrumentation				
# E363	- one disc level, to N500 or N501	add		357.00	
# E364	- each additional disc level fused, to E363	add		102.00	
	Cervical - with instrumentation including cages				
# E365	- one disc level, to N500, N501, N572, N560 or N561	add		765.00	
# E366	- each additional disc level fused, to E365	add		153.00	
	Thoracic/Lumbar - without instrumentation				
# E367	- one disc level, to N502, N503, N504, N505, N506, N507, N508 or N579	add		255.00	
# E364	- each additional disc level fused, to E367	add		102.00	
	Thoracic/Lumbar - with instrumentation including cages				
# E365	- one disc level, to N502, N503, N504, N505, N506, N507, N508, N579, N560 or N561	add		765.00	
# E366	- each additional disc level fused, to E365	add		153.00	
	Artificial Disc Insertion				
# N526	Artificial disc insertion (includes approach)		11	2040.00	17
# N525	Artificial disc insertion (approach by separate surgeon)		10	1734.00	15
# E394	- each additional level replaced, to N526 or N525	add		765.00	
# E381	- intra-operative, diagnostic or physiological neuro monitoring, to N526 and N525	add		179.30	

Note:
No other services in the Spinal Surgical Procedures section are eligible for payment when rendered with insertion of an artificial disc (N525, N526) except E394 or E381.

SPINAL SURGICAL PROCEDURES

ANTERIOR SPINAL ARTHRODESIS WITH INSTRUMENTATION WITHOUT DECOMPRESSION

			Asst	Surg	Anae
	Cervical				
# N516	One disc level		7	510.00	10
# E366	- each additional disc level fused, to N516	add		153.00	
	Thoracic - includes thoracotomy				
# N517	One disc level		9	1224.00	13
# E366	- each additional disc level fused, to N517	add		153.00	
	Thoracic - thoracotomy by separate surgeon				
# N518	One disc level		9	765.00	13
# E366	- each additional disc level fused, to N518	add		153.00	
	Lumbar - includes laparotomy/retroperitioneal approach				
# N559	One disc level		7	1122.00	10
# E366	- each additional disc level fused, to N559	add		153.00	
# E362	- combined thoracotomy/laparotomy, to N559	add		153.00	
	Lumbar - laparotomy/retroperitoneal approach by separate surgeon				
# N580	One disc level		7	765.00	10
# E366	- each additional disc level fused, to N580	add		153.00	

SPINAL SURGICAL PROCEDURES

POSTERIOR SPINAL DECOMPRESSION

			Asst	Surg	Anae
	Note: Includes hemi and total laminectomy, foraminotomy and facetectomy.				
	All levels				
# E383	- acute spinal cord injury premium	add		255.00	
# E382	- spinal duroplasty using autologous/allogenic/synthetic tissue	add		244.80	
# N521	Re-opening of laminectomy for post-op haematoma/infection		7	357.00	8
# N522	Re-opening of laminectomy for repair of CSF leak		7	535.50	8
	Note: 1. N521 and N522 are not eligible for payment when rendered with any service in the Spinal Surgical Procedures section except duroplasty (E382) if required. 2. N521 is not eligible for payment if rendered with N522.				
	Cervical / Thoracic				
# E381	- intra-operative, diagnostic or physiological neuro monitoring	add		179.30	
# N509	One level - unilateral		9	1004.70	12
# N510	One level - bilateral		9	1208.70	12
# E374	- foramen magnum decompression < 3cm as part of cervical decompression, to N510	add		357.00	
# E361	- each additional level decompressed including disc excision - unilateral or bilateral, to N509 or N510	add		255.00	
# N520	One level - laminoplasty (includes fixation of lamina)		9	1514.70	14
# E380	- each additional level - laminoplasty (includes fixation of lamina), to N520	add		357.00	
# E368	- first disc excision, to N509, N510 or N520	add		306.00	
	Lumbar				
# N511	One level - unilateral		8	800.70	9
# N512	One level - bilateral		8	1004.70	10
# E368	- first disc excision, to N511 or N512	add		306.00	
# N524	One level - bilateral canal enlargement - unilateral approach		9	1208.70	12
# E361	- each additional level decompressed including disc excision - unilateral or bilateral, to N511, N512 or N524	add		255.00	
# N571	Percutaneous discotomy		6	255.00	8
# E385	- each additional level of percutaneous discotomy, to N571	add		71.40	
	Removal of Vertebral Body including Pedicles for Osteotomy				
# N574	Above cord and conus (includes partial rib resection) - each level		9	1020.00	13
# N575	Below conus - each level		9	765.00	9
# N576	Smith Peterson Osteotomy - each level		9	255.00	9
# E381	Intra-operative, diagnostic or physiological neuro monitoring, to N574, N575, or N576	add		179.30	

SPINAL SURGICAL PROCEDURES

POSTERIOR SPINAL ARTHRODESIS FOLLOWING DECOMPRESSION OR OSTEOTOMY

Asst | Surg | Anae

All levels

# E378	- 3D stereotactic spinal procedure	add	1020.00
# E379	- 2D stereotactic spinal procedure	add	510.00

Cervical, Thoracic & Lumbar ... without instrumentation

# E369	- one disc level, to N509, N510, N520, N511 or N512	add	255.00
# E364	- each additional disc level fused, to E369	add	102.00

Cervical ... with instrumentation - by same surgeon

# E384	- C1/C2 screw fixation (transarticular, pedicle, lateral mass), to N509, N510, N560 or N561	add	1020.00
# E370	- one disc level - below C2, to N509, N510, N572, N574, N575, N576, N560 or N561	add	867.00
# E371	- fusion to occiput, to E384	add	816.00
# E366	- each additional disc level fused except fusion to occiput or fusion of cervico-thoracic junction, to E384 or E370	add	153.00
# E377	- cervico-thoracic junction, to N509, N510, E370, N572, N574, N560 or N561	add	255.00

Note:
Submit claims for levels fused in additional to E384 or E370 using one of E366, E371 or E377 as appropriate.

[Commentary:
E370 will be reduced to E366 if claimed with E384.]

Cervical ... with instrumentation - by separate surgeon

# N528	C1/C2 screw fixation (transarticular, pedicle, lateral mass)		1020.00
# E371	- fusion to occiput, to N528	add	816.00
# N513	One disc level - below C2		867.00
# E366	- each additional disc level fused except fusion to occiput or fusion of cervico-thoracic junction, to N528 or N513	add	153.00
# E377	- cervico-thoracic junction, to N513, N572, N574, N560 or N561	add	255.00

Note:
Submit claims for levels fused in addition to N528 or N513 using one of E366, E371, or E377 as appropriate.

[Commentary:
N513 will be reduced to E366 if claimed with N528.]

SPINAL SURGICAL PROCEDURES

POSTERIOR SPINAL ARTHRODESIS FOLLOWING DECOMPRESSION OR OSTEOTOMY

			Asst	Surg	Anae
Thoracic & Lumbar ... with instrumentation - by same surgeon					
# E370	- one disc level, to N509, N510, N511, N512, N572, N574, N575, N576, N560 or N561	add			867.00
# E366	- each additional disc level fused, to E370	add			153.00
# E387	- fusion to sacrum, to N511, N512, N575, N576, N560 or N561	add			153.00
Thoracic & Lumbar ... with instrumentation - by separate surgeon					
# N513	One disc level				867.00
# E366	- each additional disc level fused, to N513	add			153.00
# E387	- fusion to sacrum, to N513	add			153.00
Posterior Interbody Implant/Graft/Nuclear Replacement					
# E372	- one disc level, to N511, N512 or N513	add			510.00
# E376	- each additional disc level stabilized, to E372	add			255.00

POSTERIOR SPINAL ARTHRODESIS AS SOLE PROCEDURE

			Asst	Surg	Anae
	All levels				
# E378	- 3D stereotactic spinal procedure	add		1020.00	
# E379	- 2D stereotactic spinal procedure	add		510.00	
	Cervical & Thoracic ... without instrumentation				
# N519	C1/C2 fusion using graft/posterior wires		8	612.00	10
# N514	One disc level - below C2		7	408.00	10
# E364	- each additional disc level fused, to N514 or N519	add		102.00	
# E381	- intra-operative, diagnostic or physiological neuro monitoring, to N519 or N514	add		179.30	

Note:

1. N519 is not eligible for payment when rendered with any other fusion procedure at the same level.
2. Submit claims for levels fused in addition to N519 using E364.

[Commentary:
N514 will be reduced to E364 if claimed with N519.]

	Lumbar ... without instrumentation				
# N581	One disc level		7	408.00	10
# E364	- each additional disc level fused, to N581	add		102.00	
	Cervical & Thoracic ... with instrumentation				
# N532	C1/C2 screw fixation (transarticular, pedicle, lateral mass)		9	1224.00	11
# N515	One disc level - below C2		9	1020.00	11
# E366	- each additional level fused except fusion to occiput or fusion of cervico-thoracic junction, to N532 or N515	add		153.00	
# E371	- fusion to occiput, to N532	add		816.00	
# E377	- cervico-thoracic junction, to N515 or N572	add		255.00	
# E381	- intra-operative, diagnostic or physiological neuro monitoring, to N515 or N532	add		179.30	

Note:
Submit claims for levels fused in addition to N532 or N515 using one of E366, E371, or E377 as appropriate.

[Commentary:
N515 will be reduced to E366 if claimed with N532.]

	Lumbar ... with instrumentation				
# N582	One disc level		9	1020.00	11
# E366	- each additional disc level fused, to N582	add		153.00	
# E387	- fusion to sacrum, to N582	add		153.00	
# N533	Pars reconstruction for spondylolysis		9	1020.00	11

Note:
No other services in the Spinal Surgical Procedures section are eligible for payment when rendered with N533.

SPINAL SURGICAL PROCEDURES

FRACTURES OF THE SPINE

			Asst	Surg	Anae
# F200	No reduction, brace (includes Halo orthosis), total care by operating surgeon			178.50	
# F201	Closed reduction, fracture/dislocation (Halo or caliper traction)		5	280.50	5
# E383	- acute spinal cord injury premium, to F201	add		255.00	
# N572	Open reduction, any single level, spine fracture/dislocation, anterior/posterior		8	1020.00	11
# E395	- open reduction, additional level, spine fracture/dislocation, anterior/posterior, to N572	add		306.00	
# E383	- acute spinal cord injury premium, to N572	add		255.00	
# E381	- intra-operative, diagnostic or physiological neuro monitoring, to N572	add		179.30	
# E362	- combined thoracotomy/laparotomy, to N572	add		153.00	
# E378	- 3D stereotactic spinal procedure, to N572	add		1020.00	
# E379	- 2D stereotactic spinal procedure, to N572	add		510.00	
# N573	Anterior odontoid screw fixation		8	1020.00	11
# E378	- 3D stereotactic spinal procedure, to N573	add		1020.00	
# E379	- 2D stereotactic spinal procedure, to N573	add		510.00	
# E381	- intra-operative, diagnostic or physiological neuro monitoring, to N573	add		179.30	
# N570	Vertebroplasty (injection of bone cement) as sole procedure, first level		7	459.00	9
# E388	- vertebroplasty combined with any other procedure, first level, to other procedure	add		204.00	
# E391	- vertebroplasty, each additional level, to N570 or E388	add		204.00	
# E381	- intra-operative, diagnostic or physiological neuro monitoring, to N570 or E388	add		179.30	
# N583	Kyphoplasty (balloon tamp and injection of bone cement) as sole procedure, first level		8	969.00	11
# E392	- kyphoplasty combined with any other procedure, first level, to other procedure	add		510.00	
# E393	- kyphoplasty, each additional level, to N583 or E392	add		510.00	
# E381	- intra-operative, diagnostic or physiological neuro monitoring, to N583 or E392	add		179.30	

Note:

1. Decompressive services at the level of the fracture are not eligible for payment when rendered with N572 as they are included in the open reduction.
2. No other services in the Spinal Surgical Procedures section are eligible for payment when rendered with N573 except E378, E379 or E381.
3. No other services in the Spinal Surgical Procedures section are eligible for payment when rendered with N570 except E391 or E381.
4. No other services in the Spinal Surgical Procedures section are eligible for payment when rendered with N583 except E393 or E381.

[Commentary:
Fusion procedures are eligible for payment when performed in addition to N572.]

SPINAL SURGICAL PROCEDURES

TUMOURS/INFECTIONS OF THE SPINE

			Asst	Surg	Anae
# E386	- extradural decompression - spinal cord or cauda equina - tumour or infection	add 40%			

Note:
E386 only applies to the major decompressive procedure.

# N553	Simple soft tissue tumour excision under 5cm		6	204.00	8
# N554	Radical soft tissue tumour excision 5cm and greater		9	484.50	13

Spinal osteomyelitis

# N549	- incision and drainage including sequestrectomy, anterior approach		7	632.40	10
# N548	- incision and drainage only, posterior approach		5	102.00	5
# N550	- sequestrectomy, posterior approach		5	357.00	5

Note:
N548 is not eligible for payment when rendered with N550 as it is included in the N550 service.

# N560	Intradural extramedullary spinal tumour - partial or total removal		8	1530.00	10
# N561	Intradural intramedullary spinal tumour - partial or total removal		9	1734.00	12
# E381	- intra-operative, diagnostic or physiological neuro monitoring, to N560 or N561	add		179.30	
# E382	- spinal duroplasty using autologous/allogenic/ synthetic tissue, to N560 or N561	add		244.80	
# E383	- acute spinal cord injury premium, to N560 or N561	add		255.00	

Note:

1. No other decompressive codes are eligible for payment when rendered with N560 or N561.
2. N560 is not eligible for payment when rendered with N561.

SPINAL SURGICAL PROCEDURES

PROCEDURES ON MUSCULOSKELETAL ELEMENTS

		Asst	Surg	Anae
# Z940	Vertebral needle biopsy	5	142.80	
	Open vertebral biopsy			
# N546	- posterior approach - sole procedure	5	244.80	7
# N547	- anterior approach - sole procedure	6	306.00	8
# N551	Excision spinous process - sole procedure	5	229.50	5
# N552	Excision transverse process - sole procedure	6	382.50	8

Note:
N546, N547, N551 or N552 are not eligible for payment when rendered with any other service in the Spinal Surgical Procedures section.

SPINAL SURGICAL PROCEDURES

PROCEDURES INVOLVING NEURAL ELEMENTS

			Asst	Surg	Anae
# Z941	Percutaneous diagnostic stimulation of spinal cord, trigeminal nerve root and / or ganglion		6	331.50	8
	Note: E381 is not eligible for payment with Z941.				
# Z942	Implantation or revision of stimulation pack or leads		6	306.00	8
# Z943	Programming infusion pump or dorsal column stimulator			102.00	
# Z944	Lumbar sub-arachnoid drainage of CSF (chronic)			81.60	
# N527	Percutaneous cordotomy or tractotomy		6	469.20	8
# N529	Medullary spinal trigeminal tractotomy		10	1020.00	15
# E383	- acute spinal cord injury premium, to N529	add		255.00	
# N564	Open myelotomy for lesion - unilateral or bilateral		8	1020.00	10
# E381	- intra-operative, diagnostic or physiological neuro monitoring, to N527, N529 or N564	add		179.30	
	Note: No decompressive codes are eligible for payment when rendered with N529 or N564.				
# N523	AV malformation of cord - excision/obliteration		10	1530.00	13
# E383	- acute spinal cord injury premium, to N523	add		255.00	
# E381	- intra-operative, diagnostic or physiological neuro monitoring, to N523	add		179.30	
	Note: No other decompressive codes are eligible for payment when rendered with N523.				
# N555	Insertion / revision of implantable infusion pump			510.00	8
# N530	Implantation of spinal cord stimulating electrode by laminectomy		8	816.00	10
	Note: N530 is not eligible for payment when rendered with any decompressive codes.				
# N563	Implantation of permanent subcutaneous reservoir including laminectomy		11	510.00	11
	Note: N563 is not eligible for payment when rendered with any decompressive codes.				
# N531	Removal of any stimulation pack or electrode		6	306.00	6
	Note: N531 is not eligible for payment when rendered with any other services in the Spinal Surgical Procedures section.				
	Percutaneous vertebral facet denervation				
# N556	- one level (uni/bilateral)			142.80	5
# E396	- each additional level (uni/bilateral), to N556	add		71.40	
# N534	Percutaneous radio frequency posterior rhizotomy - any number of levels			306.00	8

NUMERIC INDEX

CODE	$	H	T	P	P1	P2	PAGE
A001	17.75						A3
A003	58.20						A1
A004	30.70						A1
A005	56.10						A1
A006	42.35						A1
A007	30.20						A3, A59
A008	10.25						A4
A013	46.20						A25
A014	29.05						A25
A015	103.85						A25
A016	50.75						A25
A023	38.70						A31
A024	20.40						A31
A025	59.15						A31
A026	44.45						A31
A033	41.20						A35
A034	22.45						A35
A035	81.60						A35
A036	46.30						A35
A043	51.45						A49
A044	26.50						A49
A045	102.00						A49
A046	51.45						A49
A055	75.35						A30
A063	39.70						A56
A064	22.45						A56
A065	66.30						A56
A066	45.85						A56
A071	53.15						A40
A073	58.25						A40
A074	45.90						A40
A075	142.80						A40
A076	75.35						A40
A078	29.05						A40
A083	39.70						A66
A084	22.45						A66
A085	66.30						A66
A086	45.85						A66
A093	41.20						A28
A094	22.45						A28
A095	66.30						A28
A096	46.30						A28
A100	76.90						A3

NUMERIC INDEX

CODE	$	H	T	P	P1	P2	PAGE
A110	40.15						A4
A112	40.15						A4
A115	42.15						A5, A54
A131	53.15						A44
A133	58.25						A44
A134	45.90						A44
A135	127.50						A44
A136	75.35						A44
A138	29.05						A44
A181	53.15						A47
A183	58.25						A47
A184	45.90						A47
A185	127.50						A47
A186	75.35						A47
A188	29.05						A47
A193	58.25						A67
A194	29.05						A67
A195	153.00						A67
A196	75.35						A67
A197	163.20						A67
A198	163.20						A67
A203	40.25						A52
A204	22.45						A52
A205	81.60						A52
A206	45.85						A52
A215	46.20						A25
A221	29.05						A38
A225	142.80						A38
A226	75.35						A38
A230	14.90						A54
A233	42.15						A54
A234	22.45						A54
A235	66.30						A54
A236	45.85						A54
A237	42.15						A54
A239	42.15						A54
A243	39.70						A58
A244	22.45						A58
A245	66.30						A58
A246	45.85						A58
A261	17.75						A59
A263	58.25						A59
A264	45.90						A59

NUMERIC INDEX

CODE	$	H	T	P	P1	P2	PAGE
A265	142.80						A59
A266	75.35						A59
A283	50.50						A46
A284	29.05						A46
A285	96.95						A46
A286	64.70						A46
A310	45.90						A63
A311	53.15						A63
A313	58.25						A63
A315	142.80						A63
A316	75.35						A63
A318	29.05						A63
A325	75.35						A38
A331	17.75						A71
A335	30.25						A71
A338	17.75						A71
A340	45.90						A73
A341	53.15						A73
A343	58.25						A73
A345	127.50						A73
A346	75.35						A73
A348	29.05						A73
A353	39.70						A76
A354	22.45						A76
A355	66.30						A76
A356	45.85						A76
A375	75.35						A40
A385	75.35						A47
A395	75.35						A67
A405	58.25						A30
A411	53.15						A34
A413	58.25						A34
A414	45.90						A34
A415	127.50						A34
A416	75.35						A34
A418	29.05						A34
A435	75.35						A44
A471	53.15						A74
A473	58.25						A74
A474	45.90						A74
A475	127.50						A74
A476	75.35						A74
A478	29.05						A74

NUMERIC INDEX

CODE	$	H	T	P	P1	P2	PAGE
A481	53.15						A75
A483	58.25						A75
A484	45.90						A75
A485	127.50						A75
A486	75.35						A75
A488	29.05						A75
A515	75.35						A63
A525	75.35						A29
A545	75.35						A34
A565	75.35						A59
A575	75.35						A74
A585	64.70						A46
A586	64.70						A46
A595	75.35						A75
A601	53.15						A27
A603	58.25						A27
A604	45.90						A27
A605	127.50						A27
A606	75.35						A27
A608	29.05						A27
A611	53.15						A43
A613	58.25						A43
A614	45.90						A43
A615	127.50						A43
A616	75.35						A43
A618	29.05						A43
A621	53.15						A29
A623	58.25						A29
A624	45.90						A29
A625	127.50						A29
A626	75.35						A29
A628	29.05						A29
A635	65.70						A50
A636	45.10						A50
A638	29.05						A50
A643	41.20						A37
A644	22.45						A37
A645	81.60						A37
A646	46.30						A37
A655	75.35						A43
A661	53.15						A59
A665	68.15						A59
A667	255.00						A59

NUMERIC INDEX

CODE	$	H	T	P	P1	P2	PAGE
C123	46.15						A7, A26 - A29, A31, A34 - A35, A37, A41, A43 - A44, A47, A49, A52, A55 - A56, A58, A61, A63, A66, A68, A73 - A76
C124	46.15						A7, A26 - A29, A31, A34 - A35, A37, A41, A43 - A44, A47, A49, A52, A55 - A56, A58, A61, A63, A66, A68, A73 - A76
C131	53.15						A44
C132	29.20						A44
C133	58.25						A44
C134	45.90						A44
C135	127.50						A44
C136	75.35						A44
C137	29.20						A44
C138	29.20						A44
C139	29.20						A44
C181	53.15						A47
C182	29.20						A47
C183	58.25						A47
C184	45.90						A47
C185	127.50						A47
C186	75.35						A47
C187	29.20						A47
C188	29.20						A47
C189	29.20						A47
C192	29.20						A68
C193	58.25						A68
C194	45.90						A68
C196	75.35						A68
C197	29.20						A68
C198	29.20						A68
C199	29.20						A68
C202	29.20						A52
C203	40.25						A52
C204	25.15						A52
C205	81.60						A52
C206	45.85						A52
C207	29.20						A52
C208	29.20						A52
C209	29.20						A52
C215	46.20						A25
C225	142.80						A39
C226	75.35						A39
C232	29.20						A55

NUMERIC INDEX

CODE	$	H	T	P	P1	P2	PAGE
C233	42.15						A54
C234	25.45						A54
C235	66.30						A54
C236	45.85						A54
C237	29.20						A55
C238	29.20						A55
C239	29.20						A55
C242	29.20						A58
C243	39.70						A58
C244	25.15						A58
C245	66.30						A58
C246	45.85						A58
C247	29.20						A58
C248	29.20						A58
C249	29.20						A58
C262	29.20						A61
C263	58.25						A61
C264	45.90						A61
C265	142.80						A61
C266	75.35						A61
C267	29.20						A61
C268	29.20						A61
C269	29.20						A61
C283	50.50						A46
C285	96.95						A46
C286	64.70						A46
C288	29.20						A46
C311	53.15						A63
C312	29.20						A63
C313	58.25						A63
C314	45.90						A63
C315	142.80						A63
C316	75.35						A63
C317	29.20						A63
C318	29.20						A63
C319	29.20						A63
C325	75.35						A39
C335	30.25						A72
C341	53.15						A73
C342	29.20						A73
C343	58.25						A73
C344	45.90						A73
C345	127.50						A73

NUMERIC INDEX

CODE	$	H	T	P	P1	P2	PAGE
E001C							GP56
E002C							GP58
E003							GP59
E004C							GP57
E005C							GP56
E006B							GP53
E006C							GP56
E007C							GP57
E009C							GP57
E010C							GP57
E011C							GP57
E012C							GP57
E013C							GP58
E014C							GP57
E016C							GP57
E017C							GP57
E018C							GP57
E019C							GP57
E020C							GP57
E021C							GP57
E022C							GP57
E041	81.55						N45
E048	108.75						N37 - N38
E049	87.20						N37, N42
E050	77.05						N9, N15, N37, N42, N50
E051	245.90						N9
E052	259.85						N9
E053	94.60						N50
E054	236.10						N9
E055	94.60						N50
E056	91.90						N15
E057							N20
E058							N21
E059							N42
E069	134.75						M10
E077	10.25						A4
E078							A27, A29, A34, A40, A43 - A44, A46 - A47, A59, A63, A73 - A75
E090	260.80						V11
E100C	-						K7

NUMERIC INDEX

CODE	$	H	T	P	P1	P2	PAGE
E101B							GP53
E102	262.70						Y7
E103	262.80						Y7
E104	415.85						Y1
E105	424.35						Y1
E106	308.30						Y1
E107	246.55						Y1
E108	131.25						Y1
E109	328.40						Y7
E117	308.30						Y2
E118	308.30						Y2
E119	453.00						Y2
E121	575.85						Y2
E122	453.00						Y2
E123	161.75						Y2
E127	166.45						Y3
E128	369.25						Y2
E130	308.30						Y3
E131	161.75						Y3
E132	370.20						Y3
E133	182.75						Y3
E134	205.55						Y3
E135	505.45						Y3
E136							Y3
E137	161.75						Y4
E138	267.35						Y4
E139	161.75						Y4
E140	413.60						Y4
E141	505.45						Y4
E142	782.35						Y5
E143	262.70						Y4
E144	314.05						Y4
E145	161.75						Y4
E146	308.30						Y4
E148	699.50						Y5
E149	181.75						Y5
E151	282.65						Y6
E152	658.55						Y6
E153	761.35						Y6
E154	182.75						Y6
E155	182.75						Y6
E158	444.25						Y6
E159	315.25						Y6

NUMERIC INDEX

CODE	$	H	T	P	P1	P2	PAGE
G355	9.60						J29
G356	33.80						J29
G357	19.55						J29
G358	24.90						J28
G359	89.55						J34
G360	49.35						J7
G361	17.60						J30
G362	6.25						J30
G363	17.60						J30
G364	17.60						J30
G365	6.75						J30
G366	148.50						J11
G367	25.55						J30
G368	54.40						J31
G369	5.30						J31
G370	19.90						J31
G371	10.00						J31
G372	2.32						J31
G373	5.30						J31
G374	54.30						J43
G375	8.85						J32
G376	10.20						J32
G377	13.30						J32
G378	25.50						J30
G379	6.15						J32
G380	27.05						J32
G381	13.90						J34
G382	11.35						J34
G383							J32
G384	8.85						J32
G385	4.55						J32
G386	38.45						J31
G389	13.90						J32
G390	223.40						J34
G391	21.10						J17
G392	50.75						J31
G393	25.35						J31
G394	6.75						J30
G395	42.25						J17
G396	24.90						J31
G397	67.75						J30
G398	41.90						J30
G400	211.15						J19

NUMERIC INDEX

CODE	$	H	T	P	P1	P2	PAGE
G401	132.00						J19
G402	52.80						J19
G403	21.15						J52
G404	61.00						J59
G405	183.10						J19
G406	91.50						J19
G407	60.95						J19
G408	105.60						J40
G409	52.80						J40
G410	68.40						J45
G411	192.10						J40
G412	211.20						J40
G413	170.85						J45
G414			25.00				J46
G415				22.60			J46
G416			15.00				J46
G417	15.90						J46
G418				37.95			J46
G419	20.10						J45
G420	11.25						J52
G421	27.70						J48
G422	34.20						J44
G423	90.30						J48
G424	174.75						J48
G425				23.90			J49
G426	9.70						J48
G427	9.60						J48
G428				6.85			J49
G429	42.45						J48
G430	86.05						J48
G431	41.60						J48
G432				14.50			J49
G433				9.90			J49
G435	5.10						J48
G436				4.80			J49
G437				22.90			J49
G438				22.15			J49
G439				24.00			J49
G440			8.80				J54
G441			12.25				J54
G442			2.78				J54
G443			8.00				J54
G444				7.00			J49

NUMERIC INDEX

CODE	$	H	T	P	P1	P2	PAGE
H001	52.20						A8
H002	32.75						A8
H003	16.25						A8
H007	61.65						A8
H055	86.10						A33
H065	57.40						A10
H101	15.00						A10
H102	37.20						A10
H103	32.25						A10
H104	15.00						A10
H105	18.45						A10
H112	15.00						A10
H113	8.80						A10
H121	26.25						A10
H122	65.10						A10
H123	54.95						A10
H124	26.25						A10
H131	16.45						A10
H132	40.90						A10
H133	35.30						A10
H134	16.45						A10
H151	22.50						A10
H152	55.80						A10
H153	47.40						A10
H154	22.50						A10
H261	57.90						A61
H262	58.20						A62
H263	17.75						A62
H267	63.45						A61
H312	29.20						A65
H313	51.70						A65
H317	29.20						A65
H319	29.20						A65
H400	72.80						GP63
H401	72.80						GP63
H402	72.80						GP63
H403	72.80						GP63
H404	72.80						GP63
H405	72.80						GP63
H406	72.80						GP63
H407	72.80						GP63
H408	72.80						GP63

NUMERIC INDEX

CODE	$	H	T	P	P1	P2	PAGE
J001	21.20						E4
J002	26.30						E4
J003	53.40						E4
J004	50.50						E4
J005	32.60						E4
J006	75.55						E4
J007	-						E5
J008	44.15						E4
J009	26.30						E4
J010	75.55						E5
J011	75.55						E5
J012	-						E5
J013	75.55						E5
J014	27.35						E2
J018	32.60						E5
J020	21.20						E5
J021	111.00						E2
J022	55.00						E2
J023	21.20						E3
J024	87.55						E4
J025	285.80						E2
J026	44.15						E3
J027	55.00						E3
J028	21.20						E5
J029	58.35						E5
J030	38.80						E4
J031	87.55						E2
J032	87.55						E3
J033	87.55						E3
J034	87.55						E3
J035	21.20						E3
J036	21.20						E4
J037	50.50						E5
J038	21.20						E5
J039	87.55						E5
J040	75.55						E3
J041	211.95						E5
J042	80.05						E4
J043	39.60						E4
J044	131.45						E4
J045	87.55						E5
J046	160.60						E5
J047	35.40						E3

NUMERIC INDEX

CODE	$	H	T	P	P1	P2	PAGE
N102	1598.45						X1
N103	1384.75						X1
N104	881.30						X2
N105	1704.50						X1
N106	1311.15						X2
N107	855.80						E2, X2
N108	1229.55						X2
N109	1878.35						X3
N110	2184.20						X3
N111	1598.45						X1
N113	614.70						X3
N115	533.20						X3
N117	1385.05						X3
N118	747.60						E2, X2
N119	901.25						X3
N120	481.90						X2
N121	1711.40						X2
N123	1076.75						X3
N124	1551.20						X3
N126	1442.95						X3
N127	450.60						X3
N128	798.80						X3
N129	963.00						X3
N130	1014.85						X3
N139	373.80						X4
N140	507.55						X4
N143	507.55						X4
N144	798.80						X4
N148	881.30						X4
N149	881.30						X4
N150	1065.45						X4
N151	1598.45						X1
N152	1451.55						X1
N153	2078.10						X1
N154	1362.35						X1
N155	1362.35						X2
N156	1229.55						X2
N157	988.60						X2
N158	881.30						X2
N159	1014.15						X2
N160	399.45						X2
N161	563.50						X6
N162	430.75						X6

NUMERIC INDEX

CODE	$	H	T	P	P1	P2	PAGE
N163	614.70						X6
N164	696.35						X6
N165	430.75						X6
N166	345.35						X6
N167	952.55						X6
N168	614.70						X6
N169	461.10						X6
N174	420.30						X5
N177	430.75						N32, X7
N183	307.40						X7
N184	165.20						N44
N188	153.70						N32, X7
N189	279.25						N13, X7
N190	215.35						N13, X7
N200	614.70						X4
N201	855.80						X6
N202	481.90						X6
N203	373.80						X6
N206	430.75						X6
N207	563.50						X6
N208	918.15						X6
N211	1116.60						X6
N212	1045.45						X6
N213	1116.60						X6
N218	1178.35						X2
N220	764.20						X5
N223	798.80						X5
N230	474.45						X5
N245	281.70						X5
N246	184.00						X5
N249	655.60						X5
N258	409.85						X5
N259	481.90						X5
N265	348.30						X5
N266	563.50						X5
N267	963.00						X5
N269	292.25						X5
N282	593.85						X7
N283	389.05						X7
N284	408.00						P8
N285	256.15						N7, N32, N41, X7
N286	317.85						X7
N287	430.75						X7

NUMERIC INDEX

CODE	$	H	T	P	P1	P2	PAGE
W109	58.20						A11
W121	22.55						A12, A32, A36, A42, A45, A48, A57, A64
W131	13.80						A45
W132	29.20						A45
W133	22.55						A45
W134	17.75						A45
W138	13.80						A45
W181	13.80						A48
W182	29.20						A48
W183	22.55						A48
W184	17.75						A48
W185	127.50						A48
W186	75.35						A48
W188	13.80						A48
W196	75.35						A68
W225	142.80						A39
W226	75.35						A39
W232	58.20						A45
W234	17.75						A45
W235	127.50						A45
W236	75.35						A45
W237	30.70						A45
W239	58.20						A45
W261	13.40						A62
W262	29.20						A62
W265	142.80						A62
W266	75.35						A62
W269	30.70						A62
W272	58.20						A41
W274	17.75						A41
W277	30.70						A41
W279	58.20						A41
W305	81.60						A53
W306	45.85						A53
W310	75.35						A64
W311	13.80						A64
W312	29.20						A64
W313	22.55						A64
W314	17.75						A64
W318	13.80						A64
W325	75.35						A39
W345	66.30						A58

NUMERIC INDEX

CODE	$	H	T	P	P1	P2	PAGE
W346	45.85						A58
W355	66.30						A77
W356	45.85						A77
W375	75.35						A41
W385	75.35						A48
W395	75.35						A68
W405	58.25						A30
W419	58.20						A64
W435	75.35						A45
W512	58.20						A64
W514	17.75						A64
W515	142.80						A64
W516	75.35						A64
W517	30.70						A64
W535	66.30						A55
W536	45.85						A55
W562	58.20						A62
W564	17.75						A62
W565	75.35						A62
W567	30.70						A62
W645	81.60						A37
W646	46.30						A37
W667	255.00						A62
W695	255.00						A68
W771	17.75						A11
W775	183.60						A41
W777	30.20						A11
W795	183.60						A68
W872	29.20						A12
W882	29.20						A12
W895	178.50						A68
W903	58.20						A11
W972	29.20						A32, A36, A42, A45, A48, A57, A64
W982	29.20						A32, A36, A42, A45, A48, A57, A62, A64
W990	18.20						GP48
W992	36.30						GP48
W994	54.55						GP48
W996	81.85						GP48

NUMERIC INDEX

CODE	$	H	T	P	P1	P2	PAGE
Z450	102.55						J23
Z451	152.40						J23
Z452	93.60						J23
Z453	20.10						J30
Z454	74.75						J31
Z455	44.70						J31
Z456	135.50						J7
Z457	39.45						J7
Z459	9.10						H4, J7
Z460	348.70						J10
Z461	523.00						J10
Z462	43.50						J30
Z463	65.30						J30
Z465	198.55						Q5
Z466	347.45						Q5
Z475	50.90						V2
Z477	17.30						V2
Z478	50.90						V3
Z480	85.30						T9
Z500	30.65						S3
Z501	35.50						S1
Z502	71.00						S1
Z503	35.40						S4
Z504	61.15						S4
Z506	50.90						S1
Z510	91.10						S1
Z511	30.65						S3
Z512	36.80						S12
Z513	107.50						S13
Z514	44.55						S12
Z515	68.25						S6
Z520	8.60						J29, S9
Z521	103.60						S3
Z522	51.25						S3
Z523	52.90						S8
Z524	271.05						S1
Z525	110.85						S8
Z526	73.60						S9
Z527	92.10						S9
Z528	67.85						S9
Z529	40.55						S8
Z530	27.35						S8
Z531	26.40						S8

NUMERIC INDEX

CODE	$	H	T	P	P1	P2	PAGE
Z532	172.95						S9
Z533	36.80						S9
Z535	36.80						S17
Z536	44.55						S17
Z537	76.70						S1
Z538	25.25						S15
Z539	25.25						S15
Z540	63.85						S15
Z541	58.15						S18
Z542	68.75						S21
Z543	6.25						S18
Z544	34.90						S18
Z545	25.25						S18
Z546	27.05						S19
Z547	99.75						S9
Z548	34.90						S19
Z549	30.95						S19
Z550	12.05						S19
Z551	70.80						S20
Z552	131.45						S26, V10
Z553	173.25						S26, V10
Z554	82.35						S20
Z555	57.70						S12
Z558	300.25						S21
Z560	92.10						S12
Z561	213.15						S21
Z562	116.20						S21
Z563	38.70						S25
Z564	73.60						S25
Z565	94.85						S19
Z566	34.90						S19
Z569	122.05						S26
Z570	49.80						S13
Z571	150.15						S13
Z574	94.85						S26
Z575	27.05						S19
Z576	35.90						S19
Z577	122.05						S23
Z578	75.00						R2
Z580	57.70						S12
Z582	105.40						V8
Z583	131.40						V8
Z584	185.15						S12

NUMERIC INDEX

CODE	$	H	T	P	P1	P2	PAGE
Z585	131.40						V8
Z590	25.25						S25
Z591	46.50						S25
Z592	49.40						S17
Z593	55.25						S21
Z594	232.50						S26
Z595	43.60						S26
Z596	314.20						S22
Z597	70.75						E5
Z600	35.50						T2
Z601	100.65						T2
Z602	8.55						T9
Z603	16.25						T9
Z604	31.60						T11
Z605	12.50						T9
Z606	71.00						T8
Z607	35.50						T8
Z608	58.65						T9
Z609	31.60						T11
Z611	8.55						T9
Z615	59.75						T12
Z616	23.55						T11
Z617	35.50						T11
Z618	77.70						T11
Z619	52.70						T12
Z620	41.65						T12
Z621	13.65						T12
Z622	5.65						T12
Z623	76.70						T4
Z624	95.95						T4
Z625	52.70						T4
Z626	95.95						T4
Z627	167.85						T4
Z628	125.65						T5
Z629	153.35						T4
Z630	314.20						T3
Z631	36.40						T4
Z632	271.35						T8
Z633	437.20						T8
Z634	437.20						T8
Z635	130.20						T8
Z636	273.25						T4
Z637	262.75						T4

NUMERIC INDEX

CODE	$	H	T	P	P1	P2	PAGE
Z700	27.80						U1
Z701	32.60						U1
Z702	23.55						U1
Z703	55.15						U2
Z704	55.15						U2
Z705	83.35						U2
Z706	120.80						U2
Z707	55.15						U3
Z708	16.25						U3
Z709	20.10						U4
Z710	55.15						U5
Z711	120.80						U6
Z712	77.70						U7
Z713	92.10						U7
Z714	17.30						V2
Z715	50.90						V2
Z716	71.90						V2
Z717	17.30						V2
Z718	174.50						V10
Z720	17.30						V7
Z721	67.75						K8
Z722	17.30						V3
Z723	50.90						V3
Z724	8.55						V7
Z725	50.90						V7
Z726	28.60						W1
Z727	57.50						W1
Z728	50.90						V3
Z729	38.35						V7
Z730	25.50						V7
Z731	50.90						V7
Z732	17.30						V7
Z733	10.55						V2
Z734	58.00						K8
Z735	50.90						V6
Z736	26.85						V2
Z737	215.80						V10
Z738	216.10						P7
Z740	63.05						M17
Z741	156.90						P7
Z742	106.45						P8
Z743	307.80						Q2
Z744	123.05						Q2

NUMERIC INDEX

CODE	$	H	T	P	P1	P2	PAGE
Z745	53.20						Q13
Z746	74.25						Q13
Z747	74.25						Q13
Z748	148.60						Q13
Z749	72.55						S12
Z750	82.35						S14
Z751	127.95						Q2
Z752	82.35						S17
Z753	24.25						S17
Z754	82.35						S17
Z755	142.40						S17
Z756	36.80						S18
Z757	40.65						S19
Z758	84.20						S19
Z759	189.55						Q2
Z760	251.85						S21
Z761	219.90						S17
Z762	82.35						S23
Z763	38.70						S25
Z764	69.80						S13
Z765	131.75						S13
Z766	78.00						V7
Z767	78.60						U1
Z768	55.15						U4
Z769	115.10						V2
Z770	29.05						V8
Z771	28.60						W1
Z772	81.45						W2
Z773	165.40						K8
Z774	93.80						K6
Z775	67.75						K8
Z776	40.80						K8
Z777	60.35						K8
Z778	102.00						K8
Z779	153.00						K8
Z780	219.80						Q2
Z781	39.00						Q2
Z782	82.55						Q2
Z783	97.35						N3, N13, N44
Z784	213.50						S17
Z785	329.65						S17
Z801	40.80						X5
Z802	81.65						X3

NUMERIC INDEX

CODE	$	H	T	P	P1	P2	PAGE
Z803	53.10						X4
Z804	41.00						J45
Z805	54.90						J45
Z807	266.60						X5
Z808	317.85						X5
Z809	241.00						X5
Z811	54.10						X1
Z812	215.35						X4
Z813	296.90						X3
Z815	107.20						X5
Z816	241.00						X7
Z818	215.35						X3
Z819	215.35						X4
Z820	317.85						X4
Z821	53.10						X5
Z823	307.40						X3, X7
Z824	266.60						X3
Z825	317.85						X4
Z826	184.00						X5
Z827	158.45						X5
Z845							Y2
Z846	50.90						Y12
Z847	26.60						Y2
Z848	38.00						Y2
Z849	26.60						Y2
Z850	95.15						Y1
Z851	52.40						Y2
Z852	74.20						Y2
Z853	74.20						Y2
Z854	40.90						Y8
Z855	81.85						Y8
Z856	81.85						Y8
Z857	26.60						Y8
Z858	65.70						Y8
Z860	26.60						Y8
Z861	26.60						Y10
Z862	52.40						Y11
Z863	74.20						Y2
Z864	80.90						Y11
Z865	160.85						Y11
Z866	50.90						Y12
Z869	39.10						N22, N36, N47
Z870	97.35						N22, N36, N41, N44, N47

NUMERIC INDEX

CODE	$	H	T	P	P1	P2	PAGE
Z871	26.60						Y2
Z873	67.75						N4
Z874	40.90						Y8
Z901	21.00						Y11
Z902	21.00						Y11
Z903	33.60						Y12
Z904	25.85						Y12
Z905	50.90						Y12
Z906	35.50						Y12
Z907	26.85						Y14
Z908	50.90						Y14
Z909	25.85						Y12
Z912	42.15						Y14
Z914	78.60						Y14
Z915	10.55						Y12
Z917	65.70						Y11
Z918	52.40						Y11
Z940	142.80						Z15
Z941	331.50						Z16
Z942	306.00						Z16
Z943	102.00						Z16
Z944	81.60						Z16

Assistant fees	**$10.40**
Anaesthetist fees	**$12.51**

CODE	$	H	T	P	P1	P2	PAGE

NOT ALLOCATED